ASHA

Which way forward...?

Evaluation of ASHA Programme

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राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

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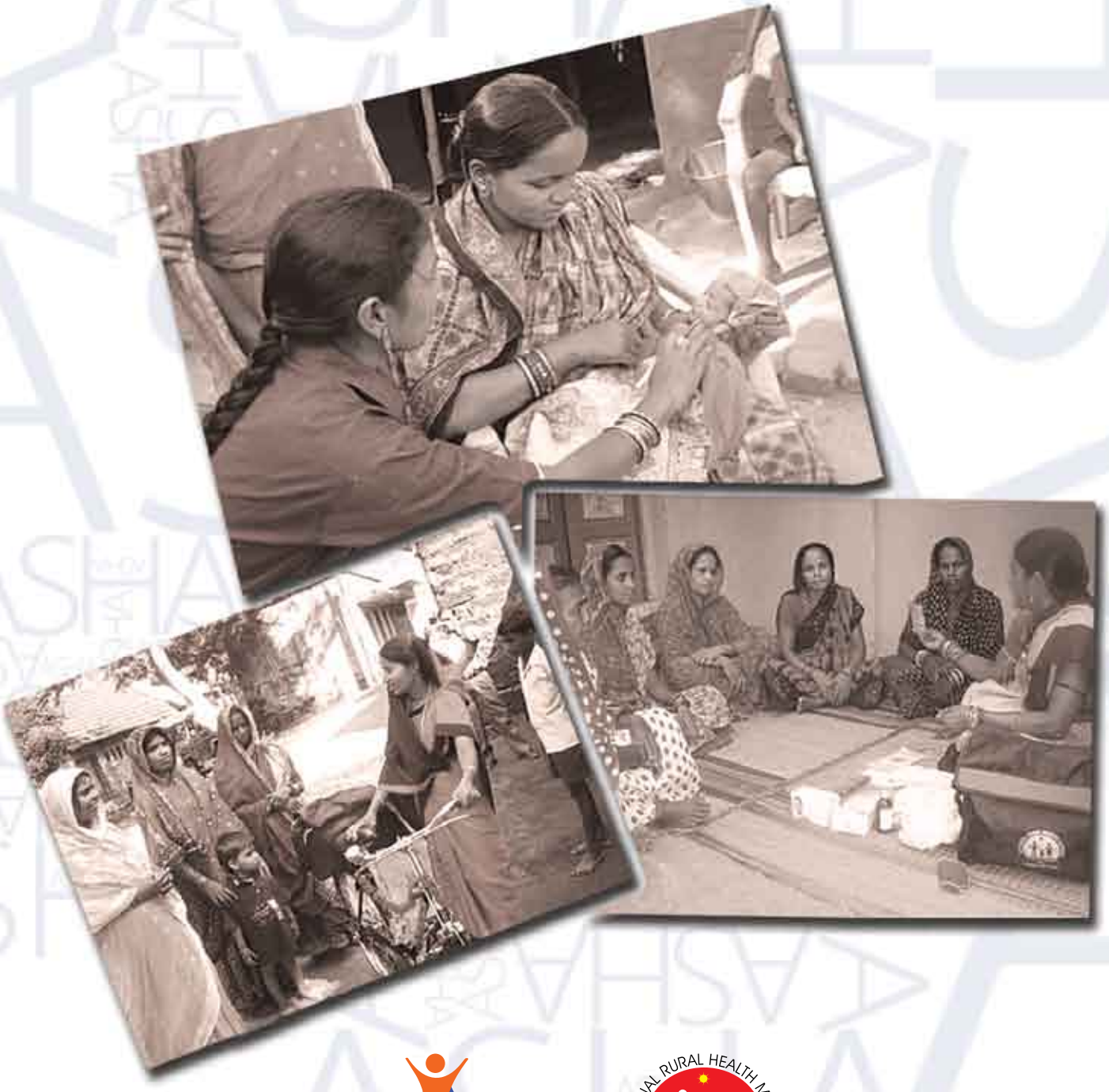

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सत्यमेव जयते

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NIRMAN BHAVAN, NEW DELHI - 110011

MESSAGE

The National Rural Health Mission has fulfilled its promise of one ASHA in every village of the high focus states. With 825,545 ASHAs in the programme, there is one for every 1000 population in almost every part of the country.

I am happy to note that this in-depth evaluation of the ASHA programme conducted by the National Health Systems Resource Center in eight States demonstrates that the ASHA appears to have gained acceptability and recognition from the community and health systems alike. In areas such as mobilisation for immunisation and promoting institutional delivery, ASHA have performed well.

The evaluation also cautions that the potential of the ASHA to make a difference in outcomes related to newborn and child hood deaths is likely to be limited, unless the necessary skill based training, support and supervisory systems are in place. Empowering the ASHA to truly integrate the multiple roles of community mobiliser, activist and provider of first contact care at the community level is the immediate challenge for the programme. The next challenge is the consideration of how to mesh the voluntary and incentivised functions of the ASHA. The third and final challenge is to chart a career path for the ASHA that would build her skills and integrate her in the country's health and human resource strategy.

The key message from the evaluation, therefore, is that there is no longer any question of "Is the ASHA programme working, but, "How do we enable her to realise her potential"? There is a strong and vibrant ASHA programme on the ground. The task that lies ahead of us is to provide the leadership needed to transform the significant investment of human and financial capital into sustainable health outcomes.

(K. Chandramouli)
13/5/11

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Message

The ASHA programme is one of the cornerstones of the National Rural Health Mission. This evaluation study conducted by the National Health Systems Resource Centre, five years after the launch of the NRHM, provides rich data on the ASHA programme in eight States.

The study findings substantiates global evidence that community health workers, trained and supported, can make a difference to health outcomes. However, the challenges to such support are not insignificant. The study findings demonstrate, that where the ASHA programme is well supported and where there is confidence in her ability to provide support and services to the mother, newborn and child, she is both functional and effective.

The ASHA programme marks a new chapter in India's experience with community health workers. Consistent attention over five years has enabled the ASHA programme to take root, but much more needs to be done to institutionalise this within the system. It's expected that States would now direct attention to issues of training quality and systems, support, timely payment and supplies, and enable the ASHA as a key resource in ensuring improvements in maternal and child survival.

(P K Pradhan)
SS&MD, NRHM

14th May, 2011

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The NHSRC study team of Dr. Rajani Ved (Team Leader), Dr. Garima Gupta, Dr. Samatha M and myself were responsible for conceptualizing and conducting the study, analyzing the data and writing the report.

Dr. T. Sundararaman
Executive Director, NHSRC

Table of Contents

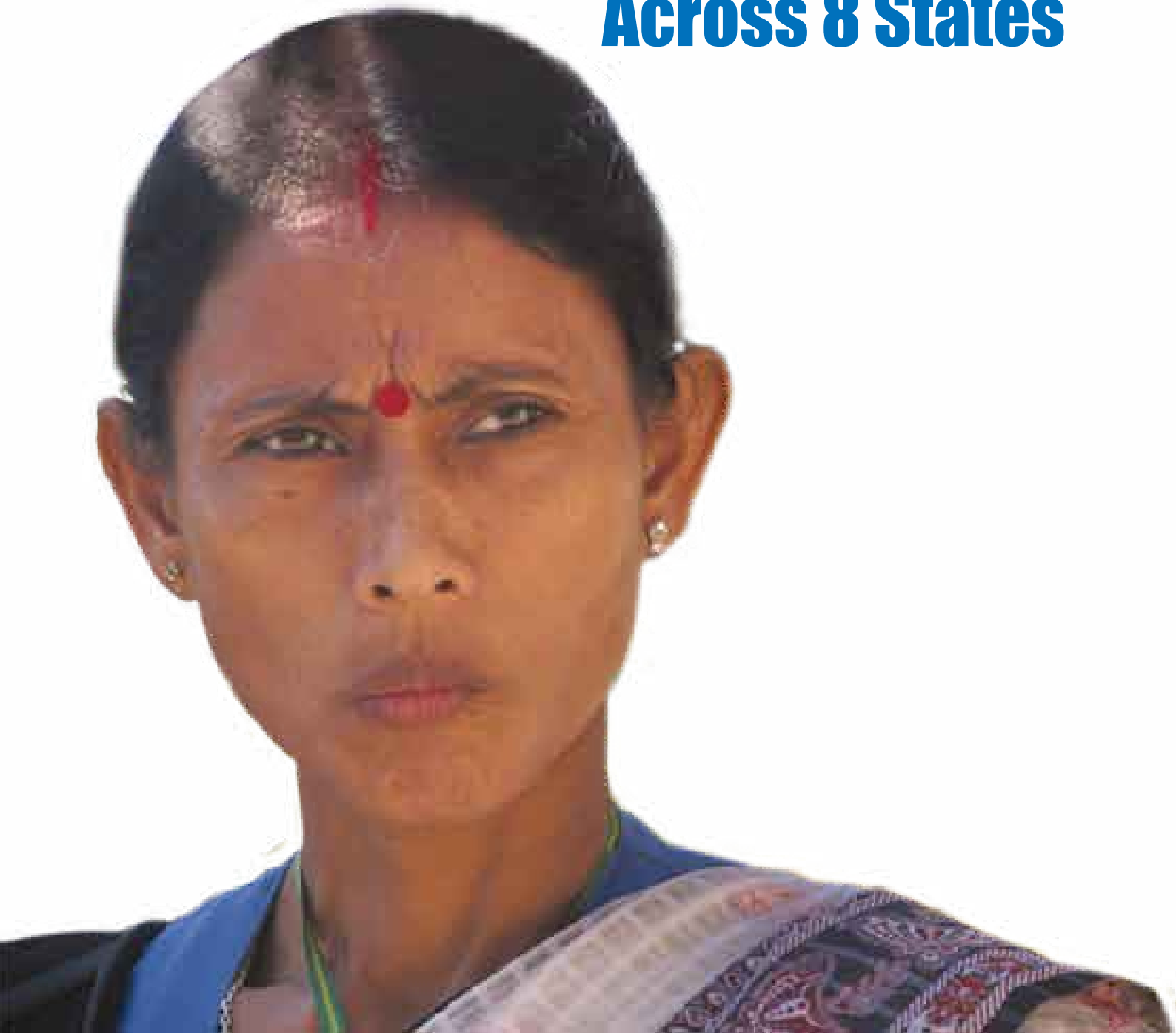
Acronyms

ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
AMG	ASHA Mentoring Group
ARC	ASHA Resource Centre
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
BAF	Block ASHA Facilitators
BHM	Block Health Managers
CHC	Community Health Centre
CPRC	Community Process Resource Centre
CWF	Department of Child and Women Welfare
DAC	District ASHA Coordinator
DCM	District Community Mobiliser
DHIO	District Health Information Officer
DPHNO	District Public Health & Nutrition Officer
DPM	District Programme Manager
DPO	District Programme Officer
DTA	District Training Administrator
GKS	Gaon Kalyan Samiti
JPHN	Junior Public Health Nurse
JHI	Junior Health Inspectors
LHV	Lady Health Visitor

NRHM	National Rural Health Mission
NERRC	North Eastern – Regional Resource Centre
MD	Mission Director
PHC	Primary Health Centre
PNC	Post Natal Care
PO DTT	Programme Officer District Training Team
PRI	Panchayati Raj Institutions
RCH	Reproductive Child Health
SIHFW	State Institute of Health & Family Welfare
SWG	Sahiyya Working Group
VHND	Village Health and Nutrition Day
VHSC	Village Health and Sanitation Committee
VSRC	Village Sahyiya Resource Centre
WFC	Women's Finance Corporation
WHSC	Ward Health and Sanitation Committee

PART I

Evaluation of ASHA Programme: A Synthesis of the Findings Across 8 States



CHAPTER 1

Background, Objectives and Methodology

I. Background

The ASHA programme is considered as being vital to achieving the goal of increasing community engagement with the health system, and is one of the key components of the National Rural Health Mission (NRHM). The ASHA is a woman selected by the community, resident in the community, who is trained and deployed and supported to function in her own village to improve the health status of the community through securing people's access to health care services. She does this through improved health care practices and behaviours and through health care provision as is essential, feasible and life saving at the community level. The term ASHA, whose meaning loosely translates to "hope" in English, was first mooted as an acronym for "Accredited Social Health Activist", but is now used as a specific term in itself. The programme launched in the 18 high focus states and tribal areas of all other states in the year 2006. Within two years over 300,000 ASHA had been selected and deployed. In response to popular acclaim and demand, the programme was expanded in early 2009 to the entire country. Today the programme exists in 31 states and Union Territories - with all but three small states (Himachal Pradesh, Goa and Puducherry) and two Union Territories (Daman & Diu and Chandigarh) having opted for the programme. With nearly 820,000 women being selected, trained and deployed as ASHA, in terms of scale and coverage, there are few precedents to the ASHA programme anywhere in the world.

However despite being hailed as the face of the NRHM, or as the flagship programme of the NRHM, there has also been considerable scepticism, even cynicism about the potential of such a largely 'voluntary' community health worker programme. Doubts have been raised about its ability to yield measurable health outcomes as well as the balance between the health benefits of such a programme, and the long term human resource management problems and costs that it would entail.

As different stakeholders worked to shape this programme in directions which they thought fit, the design and indeed every component of the ASHA programme, was subjected to vigorous debate before being articulated as policy. Even after becoming policy, at every level of implementation, the programme is subject to varying pressures to shape it in accordance with stakeholder's framework of understanding of how the ASHAs work leads to

improved health status. Even the most rigid of guidelines become malleable under such pressures and the resultant programme yields an interesting variety of field situations across the nation.

Several issues appear problematic. These include clarity on her current roles and responsibilities, questions of her effectiveness and health outcomes, the adequacy and quality of the training and support systems, questions related to her working conditions and payments and defining her future role.

Today, the ASHA programme has become an inherent part of the health system. Despite this several issues appear problematic. These include clarity on her current roles and responsibilities, questions of her effectiveness and health outcomes, the adequacy and quality of the training and support systems, questions related to her working conditions and payments and defining her future role. Clearly, this programme more than any other would benefit from evaluation studies to capture the reality of what is happening and accordingly inform decision makers of the options between which they must choose.

Evaluations of ASHA and Complex Health Interventions in General

Several evaluations have been conducted of the ASHA programme since the launch of the programme in 2006. Most evaluations have been cross-sectional in nature, providing a snapshot of the ASHA programme at a particular time, with little ability to provide information on what has changed and even less information on why it has changed. These evaluations have tended to approach the ASHA programme as a uniformly designed and implemented, vertical programme, focused on achieving certain targets which everyone is agreed upon, without attention to the differences in contexts, perceptions of key players, variations in resource availability and in institutional structures and relationships at all levels.

This is a common methodological problem with evaluating complex health interventions. One approach to evaluation designs is to obtain a cross sectional picture of the situation in a geographical area before the intervention and then again some years after the intervention. The changes seen can be compared with another area where such an intervention has not occurred-the control area. Where the base-line is known then the first cross-sectional study is not required. Where a control area is not possible, the change over time from the base-line could be compared against a counter-factual.

This evaluation approach is not possible in the ASHA programme. For one, there are no comparable areas that could act as a control – since the programme is everywhere - and the situation and context of the few places in which it is not operational, are the least comparable. Even if controls could be set up, the critical relevance of context would be lost, and in a programme like ASHA the context of the socio-political environment and that of the existing health systems as well as the historical context could profoundly alter programme mechanisms and outcomes. Another problem for evaluation is that the ASHA programme is implemented concurrently with a number of other components of the NRHM such as the Janani Suraksha Yojana (JSY) and it is impossible to isolate or attribute outcomes as being due to the ASHA programme alone. The only base lines available are state and district level data on selected health status and health service delivery indicators where the ASHA programme is only one of the many inputs - and therefore changes in these indicators would not be attributable to the ASHA alone. Baselines on many parameters of service delivery could be collected from service records but these are of varied quality and would be unreliable when collected retrospectively.

The other set of problems with this simple "before and after" cross-sectional approach is that it would not tell us why significant changes happened in some areas, partially in other areas, and not at all in the rest. Also the intervention being evaluated is not a singular technical intervention lending itself to a simple randomised controlled trial approach. They are a set of mechanisms or components, each of which interact differently with each other in different contexts and with different subjects and lead to widely different outcomes.

The ASHA programme has a process of selection, a process of training, a definition of roles, a process of providing support and monitoring, a provisioning of drug kits, and a process of making payments and so on and each of which varies widely from state to state, despite common national guidelines. Thus if the programme works or fails it could be attributed to one or the other of these components and not necessarily to all of them, much less attributed to the programme as a whole. Also the subjective factors – the perceptions of key implementers – would make a major difference to programme outcomes. Thus asking the question – "Does the ASHA programme work" or an even more focussed question such as "Does the ASHA programme reduce neonatal mortality," is a far more complex question than, "Does measles vaccine prevent measles" or "Is chloroquine effective against malaria?" The challenge was to devise a methodology that could attempt to look at the complexity and subjective elements objectively. An approach that is neither "positivist" nor "relativist" – which is what perhaps is meant by the term realistic. (Pawson, R., & Tilley, N. (2004). *Realistic Evaluation*. London: SAGE Publications Ltd.)

The problem of evaluating ASHA is further compounded by multiple and contesting narratives of what constitutes the legitimate role of the ASHA. This is not a value-neutral discourse which objective evidence would settle once and for all.

Evaluations using cross-sectional studies, provide a good description of the current status, but face difficulties in providing evidence to support the recommendations. Not surprisingly, most recommendations do not get acted upon, although this is as much reflective of the problems of evaluation as it is of programme governance.

The problem of evaluating ASHA is further compounded by multiple and contesting narratives of what constitutes the legitimate role of the ASHA. The discourse on the ASHA's role, centres around three typologies - ASHA as an activist or rights worker, ASHA as a link worker or facilitator, and ASHA as a community level health care provider. Not only does the "success and failure" of the ASHA programme mean very different things to different stakeholders, the interpretation of every major finding and the acceptability of every major recommendation would hinge upon the position each person has in relation to this discourse. This is not a value-neutral discourse which 'objective' evidence would settle once and for all. What a good evaluation can do, is only help build up areas of common understanding and consensus between highly divergent positions, so that the common and legitimate social goals that all are agreed upon would be easier to reach.

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The goal of this evaluation is to therefore explore the diversity within the ASHA programmes in different states, to provide information on how in different contexts, different choices have been made in relation to programme mechanisms, to understand why these choices were made and to understand how these differing mechanisms interacted in their specific contexts to yield varying outcomes. Simply then, the goal of this evaluation is – not the simplistic question-***Does the ASHA programme work***-but rather: "What ***Components of the ASHA programme work, and Where, under What Circumstances and to what Extent does it work?***

The findings of this evaluation report will serve as the basis for dialogue with local, state, and national programme managers, in order to improve the functioning of ASHA programmes for better health outcomes. Its recommendations could make use of various "natural experiments" that have occurred on the field, due to varied interpretations of guidelines and differences in processes deployed.

The findings of this evaluation report will serve as the basis for dialogue with local, state, and national programme managers, in order to improve the functioning of ASHA programmes for better health outcomes.

The report is organised in two parts. The structure of Part 1 is as follows: The remainder of this first chapter lays out the objectives and methodology of the evaluation, Chapter II discusses key findings with regard to the policy framework and institutional mechanisms in the eight states. This chapter spans the context and mechanisms, national guidelines, role definitions of the ASHA, management structures in the state, viz: the political and administrative leadership accorded the programme, training, incentives and payments, drug kits, role of ASHA in community mobilisation and social exclusion, and finally the programme theory of various officials at various levels. Chapter III reviews the profile of the ASHA in the states and districts, and includes information on age, marital status, educational qualifications, economic status, social and community identity of ASHA, population coverage or access, and the reach to marginalised communities. Chapter IV examines the data for ASHA's functionality across a range of services. The data includes the ASHA's point of view as well as those of beneficiaries, who were actual recipients of the services. Chapter V analyses the determinants of effectiveness and describes the relationship between ASHA's functionality and effectiveness discussing various tasks that she undertakes. Chapter VI is a discussion of the context-mechanism outcome configuration leading to the conclusions of the study. The concluding Chapter VII contains the recommendations.

Part 2 Section I contains state specific findings related to the topics in Chapter II, viz: the policy framework and institutional mechanisms, Section 2 is a set of eight comparative case studies focusing on the national guidelines for the selection criteria and divergences at state and district levels. Section 3 includes the state specific data tables on the ASHA's functionality and effectiveness as discussed in Chpater V.

II. Objectives of ASHA Evaluation

Its recommendations could make use of various "natural experiments" that have occurred on the field, due to varied interpretations of guidelines and differences in processes deployed.

The objectives of the evaluation were to:

1. Understand the evolution of the programme, stakeholder perspectives and experiences of key stakeholders given the specific socio-political and institutional environment.
2. Understand the characteristics of the ASHA, her beneficiaries, support structures and roles assigned to her.
3. Assess the ASHA's work outputs and attributable health outcomes. This includes a measurement of the programme's effectiveness in bringing about changes in health behaviour, utilisation of health services and response to community's felt needs especially with respect to common illness in young children.
4. Review quality of key processes and mechanisms that constitute the programme, such as: selection, training, monitoring support structure and community ownership.
5. Use findings and recommendations of the evaluation to provide feedback to programme managers, ASHAs and other key stakeholders and enable modifications to strengthen the ASHA programme and define her role for the future.

6. Assess the extent to which such evaluations strengthen programme implementation.

Domains Covered

In order to meet these objectives, the evaluation covered the following domains.

The study was conducted in three phases using a mixed method approach. Phase I was a qualitative study and a review of secondary data. Phase II was a structuredquestionnaire based sample survey.

Theme One: Governance, Institutions, Expectations and Perceptions

This includes an over view of the programme, the policy framework and its evolution, a description of the institutional environment of the scheme, the adaptations in process guidelines made if any, and the perception, interaction, contribution of different stakeholders. Such stakeholders would include the government personnel at different levels, the NGO sector and professional bodies, peripheral health workers, and Panchayati raj institutions.

Theme Two: Understanding ASHA and the programme dynamics

- The profile of the ASHA.
- The processes of selection and support-payment, drug kits, monitoring and supervision etc.
- Nature of interaction with other health staff and key stakeholders at the community level.
- The training process and systems.
- Beneficiary and community perceptions of ASHA's role.

Theme Three: Outcomes of the ASHA programme

- The knowledge and skill levels of ASHA.
- The tasks undertaken by ASHAs – as a facilitator of public health services, as a care provider during illness, as a health educator, and as a social mobiliser and an activist.
- Measurable outcomes and outputs of the ASHAs work in terms of changes in health behaviour, in utilisation of health services and in response to illness in childhood.
- The relationship between contexts, mechanisms and outcomes. The determinants of outcomes in terms of knowledge and skills, programme processes, contextual factors, social barriers and systems responsiveness.

To strengthen implementation together they covered three major themes: governance, institutions, understanding the ASHA and the outcomes of the programme.

III. Methodology

The study was conducted in three phases using a mixed method approach. Phase I was a qualitative study and a review of secondary data, intended to comment on Theme 1 and partly on Theme 2. Phase II was a structured questionnaire based sample survey that covers issues of Themes 2 and 3. Phase 2 findings are correlated with those of Phase I to complete the analysis

and arrive at the conclusions and recommendations. Phase 3 is an ongoing phase, in which the findings and recommendations are discussed with key stakeholders at national, state and district level, and a two year prospective observation on how the findings and insights are used by programme managers and policy planners, and assess the changes triggered by the evaluation to programme implementation and perceptions of implementers.

Choice of study districts and states

It was decided to focus on a short list of 8 states chosen purposively to capture divergent contexts and mechanisms. Each state was evaluated separately and then a cross-state comparison was undertaken.

Within each state two districts were purposively selected:

- Best performing district as adjudged by programme managers based on the training and support structure.
- District with higher proportion of disadvantaged groups in the population – with a moderate performance or where there is an important variation in performance design.

The sample sizes of phase II were adequate to comment on each district. Thus in a sense there are sixteen distinct district level case studies between which the CMO relationship-the context-mechanism-output/outcome relationship is compared. The comparisons are used as the basis to arrive at the conclusions. Given this design, there is never at any point any move to crunch the data from all eight states to achieve a national status report. That cannot be done with this data given the purposive selection of state and districts with divergence as the main criterion. Also such a pronouncement or final judgement is not one of the objectives of the evaluation.

The eight states chosen and the reason for choice are listed in Table 1:

Phase One: This phase of the study was undertaken between November 2009 and March 2010. The questions of this qualitative phase address the issues of Theme-1 and to some extent the second theme, i.e. governance, institutional mechanisms, management structures, stakeholder relationships and perceptions. Secondary data was also analysed and used for defining the tools for the phase two of the evaluation. The main methods were in depth interviews and a few focus group discussion conducted by two senior researchers for each state. The interviewers were drawn from academic backgrounds or from non government organisations with experience in qualitative studies. (Annexure-1). Those interviewed were key programme officers and NGOs at the centre, and the Mission Director, state nodal officers, two State ASHA Mentoring Group members, ASHA resource centre staff at the state level. In the district those interviewed included the Block Medical Officer (MO), Chief Medical Officer (CMO), District Programme Manager (DPM), District Community Mobiliser (DCM) and some ANMs and ASHAs. This phase also provided inputs to finalise questionnaire for the next phase.

The sampled respondents in each district were as follows: 100 ASHAs, 600 service-users (beneficiaries), 25 ANMs, 100 AWW, and 100 representatives of the Panchayati Raj Institutions.

Phase Two: Focused on addressing issues in Themes 2 and 3. A quantitative survey tool was prepared, field tested and finalised in March and April 2010. This was administered to randomly selected respondents in each district in May 2010 to August 2010.

The sampled respondents who were administered the questionnaire was as follows: 100 ASHAs, 600 service-users (beneficiaries), 25 ANMs,

Table 1:

State	Reasons for choice	Districts chosen
1. Andhra Pradesh	- One of the earliest programmes-launched before the NRHM. - Example for "non-high focus" state situation. - Intensive, innovative training approach led by NGO with a focus on the role of the ASHA as an activist for women's health issues.	**East Godavari:** Well developed and good performing district. **Khammam:** Tribal district with average indicators.
2. Assam	- Only state other than Chhattisgarh where support structures as envisaged in the national guidelines were in place.	**Dibrugarh:** Well developed, and good performing district. **Karimganj:** Tribal district with average indicators.
3. Bihar	- A programme which has faced major management challenges. - Training still in first round in many districts. - Also typical of the large poor performing state situation.	**Purnia:** Well performing district. **Khagaria:** High SC population with average indicators.
4. Jharkhand	- The state's "Sahiyya" programme predates NRHM, with a greater NGO involvement and attention to mobilisation.	**Dhanbad:** Good performing district. **West Singhbhum:** Tribal district with average indicators.
5. Kerala	- An unlikely programme in a non high focus state, where RCH is an almost completed agenda. - ASHA were expected to address non communicable diseases.	**Trivandrum:** Urbanised well developed and good performing district. **Wayanad:** Tribal district with average indicators.
6. Orissa	- A high focus state with a high tribal population. - One state that has followed many of the key tenets of ASHA programme design.	**Angul:** Good performing district. Special emphasis on newborn survival. **Nayagarh:** Tribal district with poor indicators.
7. Rajasthan	- A convergence model with the ICDS programme. Substantial IMNCI input to the ASHA. - A fixed monthly honorarium approach.	**Bundi:** Well developed district with good indicators. **Banswara**: Tribal and hilly district with poor indicators.
8. West Bengal	- A NGO led training programme in a non high focus state. Slow rate of expansion. - Fixed monthly wage in practice. Strong Panchayat system.	**Malda:** Large non tribal. district with better indicators. **Birbhum:** Tribal district with poor indicators.

100 AWW, and 100 representatives of the Panchayati Raj Institutions. The service users were of two categories-one was service user A: Mothers with children of 0–6 months of age, of which there were 400 and the other was service user B: Mothers of children between age 6 months to 2 yrs, of which there were 200.

Two categories - Service user A: Mothers with children under the age of 0–6 months of age, of which there were 400. Service user B: Mothers of children between 6 months to 2 yrs who had an illness in the preceding month, of which there were 200.

The process of selection of these respondents was as follows:

a) A master list of ASHAs in the district was prepared.

b) From this master list of all ASHAs, 25 ASHAs were randomly selected.

c) Each ASHA represented the node of a cluster and three more ASHAs from the three villages nearest to the nodal ASHA were also selected.

d) A listing was done of all "women with children under 6 months of age" (potential service-users A) and "women with a child between 6 months – 2 yrs of age who had any episode of childhood illness in last one month" (potential service users B) in the selected villages.

e) All women in the above two categories were met and those who confirmed having met the ASHA for a relevant service from her in this period were listed as "actual beneficiaries". This list of potential service users related to actual service users was used to estimate the ASHAs coverage or outreach.

f) From these actual service users a random sample of four service users of type A and two of type B were selected. These service users or beneficiaries were asked what services they received. This was used to understand the range and quality of services provided and further estimate coverage for different service components of those services users who were reached.

g) Further one Anganwadi worker and the elected Panchayat member from that village where an ASHA was selected was also selected for administration of a questionnaire.

h) Finally one of the ANMs from that cluster of villages was selected. Usually there would be one or two ANMs servicing the village cluster served by 4 or 5 ASHAs.

200 ASHAs were interviewed in Andhra Pradesh, Kerala, Rajasthan, Assam and Orissa. In Jharkhand 197 and in West Bengal 184 ASHAs were interviewed by the study team. This short fall in Jharkhand and West Bengal was due to rejection of some questionnaires due to incomplete data.

Reputed NGOs or academic institutions who were not administratively or organisationally accountable for the ASHA programme in that state were selected to conduct the survey.

Each respondent was interviewed by a three person team. Reputed NGOs or academic institutions who were not administratively or organisationally accountable for the ASHA programme in that state were selected and they recruited the research assistants for conducting the survey from the districts. (Annexure-2) Data entry and tabulation was centralised. Data analysis was carried out separately for each district and state, so as to be able to build an understanding of who is the ASHA and of programme dynamics as well as comment on the outcomes of the programme.

Analysis took three months-from September 2010 to November 2010. The draft report was presented to the National ASHA evaluation committee in December 2010 and the final report was released for discussion in January 2011. Detailed tables of the evaluation are available on NHSRC website and can be accessed on http://nhsrcindia.org/thematic_data.php?thematic_resources_id=1.

IV. Framework of Analysis

Given the complexity of the programme components, mechanisms, the variability of the context and the large range of eventual outcomes, a framework of analysis was developed.

The framework of analysis rests on three distinct questions:

Q1. Who is the ASHA? What is the profile of the woman who has emerged as ASHA? How much time does she spend on her work? How many persons/

families does she provide services for? How has the selection process affected this?

Q2. What are the tasks ASHA is doing (***functional)*** and to what extent is she ***effective*** in bringing about an outcome and what is her **coverage** (the percentage of potential users that she actually reached). Functionality and effectiveness are seen as related to three categories of activities-one is facilitation where her task consists of getting the user to a health facility or professional service provider (midwife, nurse or doctor, either public or private). The second set of activities relates to service provision. Service provision includes counselling and health education-to prevent illness, to promote good health practices, and to respond correctly to illness. Service provision also includes diagnosis of illness and appropriate action – referral, drugs, home remedies or counselling-by the ASHA. The third set of activities is mobilisational and relate to securing entitlements, holding village meetings, promoting collective action for prevention of disease or access to services, and reaching services pro-actively to the most marginalised sections, all of which could be termed as the activist role.

Q3. How do functionality and effectiveness relate to programme dynamics? What are the main constraints to effectiveness?

To answer the first question we describe the profile of the ASHA in each of the study districts and states and then comparing across states we analyse these divergences in profiles and relate these to differences in process of selection of ASHAs and the context in which she is selected. The profile of the ASHA includes her age, marital status, family and local support, socio-economic profile, educational level, the area that she has to cover, as well as her subjective desires of why she chose to become an ASHA. The last is so important, that we could express the selection outcome as an outcome of the policy framework, the context, the power and involvement of different stakeholders *and the choices women made*.

To get more specific and reliable answers on **functionality** we pose the question to the ASHA in terms of what she actually did in the last month for a sick child, and in the last six months for a newborn in her area or for a pregnant woman. We understand functionality as having four determinants a) profile of the ASHA, including selection process b) the policy framework of the ASHA-in terms of what the system as experienced by her expects her to be doing c) the incentivisation of her work-both in theory and in practice and finally d) her own agency in the context of the community's felt needs-how she finds it necessary to respond to community needs. Questions and responses related to functionality covered a very large set of tasks-which include – JSY; immunisation day (Village Health and Nutrition Day) related tasks, care in pregnancy, care for the newborn and the sick and malnourished child, family planning promotion, action on disease control especially tuberculosis and malaria, community mobilisation in different forms, and counselling and communication for health and nutrition promotion. Functionality is also estimated from service users responses-where we ask whether the ASHA counselled for or otherwise promoted a particular action, or provided a drug or other services.

We understand functionality as having four determinants a) profile of the ASHA, including selection b) the policy framework of the ASHA-in terms of what the system expects her to be doing c) the incentivisation of her work-both in theory and in practice and finally d) her own agency in the context of the community's felt needs.

For estimating overall **coverage** rate for each of the two user categories, we relate the "actual service users" to the "potential service users". If some components of the services were delivered to only a part of the actual service

users, we can multiply the overall coverage rate by the rate of delivery of this component to estimate the coverage rate for that component.

Effectiveness is related to a) the knowledge and skills of the ASHA b) the responsiveness of the health systems to cover the last mile-in terms of how well a facility responds to a patient brought to it, contributions needed from other service providers, willingness to support ASHA with drugs, and supportive supervision for community level tasks. Effectiveness is measured in terms of those responses which could be proxy for main health outcomes. Most of these are still process outputs and not eventual impact outcomes-but since they correlate closely to health impacts they could be taken as indicative.

To illustrate

An ASHA is said to be 'functional" on promoting breast-feeding in the first hour or birth, if a service user reports that she was counselled by ASHA on exclusive breast-feeding.

An ASHA is said to be "effective" on promoting breast-feeding in the first hour of birth is a service user reports that she actually breast-fed the baby in the first hour after birth.

The ASHA would have been functional-but not effective if the mother had not breast-fed despite counselling which we attribute to a lack of skills or because the quality and extent of intervention by the ASHA was insufficient to create the change.

To take another example

An ASHA is said to be effective in care for diarrhoea if a young child with diarrhoea for whom she has advised ORS, actually gets and takes ORS and if a child she has referred for dehydration actually visits a health facility and is treated for it.

An ASHA is said to be functional in care for diarrhoea in a young child if she is seeing sick children with diarrhoea and referring those with dehydration and advising ORS to the others.

An ASHA is said to be effective in care for diarrhoea if a young child with diarrhoea for whom she has advised ORS, actually gets and takes ORS and if a child she has referred for dehydration actually visits a health facility and is treated for it there. We would have liked to measure whether deaths due to diarrhoea were reduced-but this was not possible. We assume that if all children with diarrhoea took ORS and all those referred for dehydration actually reached and were treated in a facility-mortality due to diarrhoea would decline-a reasonable assumption. Of course in this example the gap between a functional ASHA and an effective ASHA is huge. An ASHA could be functional on meeting and advising all children with diarrhoea, but she would need to have ORS supplies in her kit, skills to diagnose dehydration, skills to make home based ORS, the family should be able to get transport and the facility should be accessible which would provide care for dehydration at the costs they can pay, for ASHA's functionality to lead to effectiveness in terms of health outcomes.

This latter example illustrates both the challenges of programme management and of programme evaluation. In all that really matters-newborn survival, appropriate care for the sick child, identification and management of complications in pregnancy, securing entitlements of health care-there is indeed a huge gap between functionality and effectiveness. Further, in contexts of poor health status baselines and weaker health systems - the gap between the two is even more and that is a huge challenge for evaluation.

CHAPTER 2

The Policy Framework and Institutional Mechanisms

I. Evolution of the Policy Framework and Design

The Policy Framework for ASHA was enunciated as part of the policy framework of the National Rural Health Mission, of which it is a component. Its programme design is expressed in the ASHA guidelines issued by the Ministry of Health and Family Welfare in year 2006. At the national level, the guidelines lay out three roles for ASHA: that of a facilitator of health services, of a service provider and that of an activist.

This role definition of ASHA evolved through serious advocacy efforts by concerned civil society activists, resulting in a significant revision of the first concept note of NRHM that was issued by the MoHFW[1]. In 2004, Dr. N.H. Antia, the eminent social health activist and a pioneer in community health worker programmes led a team of civil society representatives to the Prime Minister's office to present a note on the concerns on the narrow definition of the ASHA. MoHFW was persuaded to reconsider the role of ASHA through national consultations with civil society. The team had raised the concern that an ASHA, who was, as of then, envisaged as a mere commission agent for mobilising family planning cases and promoting institution delivery would be a lost opportunity, would create more problems than it would solve and was not in conformity with the spirit and experience of CHW programmes.

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This intervention contributed to the creation by MoHFW, of a multi-stakeholder task force to design the ASHA programme and this led to the official definition of the roles and responsibilities of the ASHA. This task force was one amongst about ten task forces that recommended on different dimensions of the NRHM. The Task Force recommendations were enshrined in the, ***"ASHA Guidelines,"*** issued by the Ministry of Health and Family Welfare. The articulation of the roles and responsibilities of the ASHA in these guidelines are shown in the next page. Several of the civil society representatives on the task force were encouraged to continue their contribution as part of a National ASHA Mentoring Group, instituted by the MoHFW to provide ongoing guidance and policy support to the programme at the national level.

1 Population Foundation of India: Discussion note on the Community Health Worker in the Rural Health Mission, November 28, 2004; Advocacy Papers on Population Issues, 2010.

The XI Five Year Plan (2007–2012) also highlighted home based care, delivered through a community health worker as a key strategy to reduce newborn and infant mortality.

The XI Five Year Plan[2] (2007–2012) also highlighted home based care, delivered through a community health worker as a key strategy to reduce newborn and infant mortality. This reinforced the roles and responsibilities of the ASHA as articulated in the guidelines.

The ASHA and community processes component was initially included as a part of NRHM for the High Focus states only. These are 18 in number, and comprise Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Uttar Pradesh, Uttarakhand, Rajasthan, Orissa, the North Eastern states, Himachal Pradesh and Jammu and Kashmir as hilly states. Of these Himachal Pradesh chose not to opt for the ASHA programme. For the remainder, twelve Non High Focus states and 5 Union territories the guidelines permitted ASHA selection in tribal, coastal or other difficult districts. Goa and Puducherry amongst the states, and Daman & Due and Chandigarh amongst Union Territories did not opt for the ASHA programme. Kerala on the other hand bartered its second ANM funding in return for sanction to implement a state-wide ASHA programme. In January 2009, responding favourably to a very positive political and administrative feedback from the states, a decision was taken to extend the programme within even the non high focus states to cover the entire country. Except in Tamilnadu, which kept the programme limited to tribal areas, all other states opted for this expansion. By end 2010, the total number of ASHAs had risen to 8,25,000.

Of the states selected for the evaluation, the ASHA programme was launched in 2005 in Orissa, Rajasthan, Bihar, and Assam. Jharkhand had initiated the Sahiyya programme before the NRHM was launched, drawing several design elements from the Mitanin programme in nearby Chhattisgarh[3]. In Rajasthan the state opted to nominate the helpers of the Anganwadi Centres, called Sahayoginis as the ASHA (now renamed ASHA – Sahayogini). Of the three non high focus states, Andhra Pradesh had launched a state wide Women Health Volunteer scheme in 2005, much before the NRHM approved expansion of the ASHA programme state wide, and these were renamed ASHA. Thus when in 2005, the ASHA programme was included as part of the NRHM, there was already a trend in the country of reviving Community Health Worker (CHW) programmes. From 2005 to 2009, the states of West Bengal and Kerala, had selected ASHA only for tribal districts, as mandated by the central guidelines. In 2008, both states opted to scale up the ASHA programme state wide.

Historically this is not the first, though it is certainly the largest, CHW programme to have been launched in India. For a person new to the Indian CHW context, we trace a brief history of the evolution of CHW concept, leading to the ASHA in India. There are many ways and versions in which this history could be told, and we have tried to give emphasis to those threads which are most directly connected to the evolution of the ASHA programme.

2 Planning Commission, Government of India, Eleventh Five year Plan, (2007-2012).

3 The Mitanin programme was established by the Chhattisgarh state government in 2003.

Roles and Responsibilities[4]

- ASHA will be a health activist in the community who will create awareness on health and its social determinants and mobilise the community towards local health planning and increased utilisation and accountability of the existing health services. She would be a promoter of good health practices. She will also provide a minimum package of curative care as appropriate and feasible for that level and make timely referrals. Her roles and responsibilities would be as follows.
- ASHA will take steps to **create awareness** and provide information to the community on determinants of health such as nutrition, basic sanitation and hygienic practices, healthy living and working conditions, information on existing health services and the need for timely utilisation of health and family welfare services.
- She will **counsel** women on birth preparedness, importance of safe delivery, breast feeding and complementary feeding, immunisation, contraception and prevention of common infections including Reproductive Tract Infection/Sexually Transmitted Infection (RTIs/STIs) and care of the young child.
- ASHA will **mobilise the community and facilitate them in accessing** health and health related services available at the village/sub-centre/primary health centres, such as Immunisation, Ante Natal Check-up (ANC), Post Natal Check-up (PNC), ICDS, sanitation and other services being provided by the government.
- She will **work with the Village Health and Sanitation Committee of the Gram Panchayat** to develop a comprehensive village health plan.
- She will arrange **escort/accompany** pregnant women and children requiring treatment/admission to the nearest pre-identified health facility i.e. Primary Health Centre/Community Health Centre/First Referral Unit (PHC/CHC/FRU).
- ASHA will **provide primary medical care** for minor ailments such as diarrhoea, fevers, and first aid for minor injuries. She will be a provider of Directly Observed Treatment Short-course (DOTS) under Revised National Tuberculosis Control Programme.
- She will also act as a depot holder for essential provisions being made available to every habitation like Oral Rehydration Therapy (ORS), Iron Folic Acid Tablet (IFA), chloroquine, Disposable Delivery Kits (DDK), Oral Pills and Condoms, etc. A Drug Kit will be provided to each ASHA. Contents of the kit will be based on the recommendations of the expert/technical advisory group set up by the Government of India.
- Her role as a provider can be enhanced subsequently. States can explore the possibility of graded training to her for providing newborn care and management of a range of common ailments particularly childhood illnesses.
- She will **inform** about the births and deaths in her village and any unusual health problems/disease outbreaks in the community to the Sub-centres/Primary Health Centre.
- She will promote construction of household toilets under Total Sanitation Campaign.

4 Excerpted from Accredited Social Health Activist (ASHA) Guidelines, (pages 8-9) National Rural Health Mission, Ministry of Health and Family Welfare, Government of India, 2006.

Salient History of the CHW concept

A widely accepted definition of the CHW, developed by a WHO Study Group, is that "community health workers should be members of the community where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by health system but not necessarily a part of its organisation, and have shorter training than professional workers" (Kahssy, et al, 1998:4).

History of the Community Health Worker (CHW) and its practice in government policy

1940: The Planning Committee of the Indian National Congress, chaired by Jawaharlal Nehru, recommends the training of one health worker for every 1000 people within 5 years (cited by Ashish Bose, 1983).

1975: The Report of the Group on Medical Education and Support Manpower' popularly known as the Srivastava Committee Report, (1975), proposes the CHW formally as a major part of the health system: '"What we need therefore, is the creation of large bands of part-time semi professional workers from among the community itself who would be close to the people, live with them, and in addition to promotive and preventive health services including those related to family planning, will also provide basic medical services needed in day-to-day common illnesses which account for about eighty per cent of all illness". (The quote goes on to stress that the CHW, should not supplant or compete in any way with the formal health system).

1978: The Path-breaking conference Alma Ata conference on Primary Health Care (1975) advocates the CHW as a central agency to advance primary health care. Calls for the creation of national level CHW programmes to be able to serve unreached populations, especially village communities and their unmet health needs.

1978: The Government of India introduces the CHW programme for providing "adequate medical care where such care is needed, and to educate the people in the matter of preventive and promotive health (NIHFW, 1983:17): The CHW was envisaged as a catalytic change agent to assist communities to realise "that the health status of the rural population can be improved not merely by increasing the numbers of doctors or increasing the output of medicines, but by making each individual realise and appreciate the need of simple steps in sanitation, preventive, promotive and rehabilitative health activities". The village communities would select these CHW for every 1000 people, training would be by the PHC, monthly stipend paid and drug kit provided for simple illnesses. In 1981, the programme was renamed the Village Health Guide scheme. The scheme comes to a close around 1985, though some states continued with it into the nineties.

1995: The Jan Swasthya Raksha (JSR) Scheme, introduced state-wide by the Government of Madhya Pradesh in 1995. In this instance, curative care with fee for service approach is seen as the central approach. Programme closes around 2002. Very limited role in provision of preventive and promotive care and very few links to public sector practice.

2002: The Mitanin Programme, introduced in Chhattisgarh in 2002 and scaled up state-wide in 2004. Women health workers whose roles are defined as a mix of community level care provision, facilitator and activists. With 54,000 CHWs selected, trained and deployed, this is a successful scaling up of a sustainable model at a state level. Revived interest in government led CHW programmes.

2005: The Women Health Volunteers Scheme (WHV) in Andhra Pradesh selects, trains and deploys 70,000 health volunteers (later to be renamed ASHAs).

2005: Jharkhand starts off Sahiyya Programmes- in a number of pilot blocks. Sahiyyas are later declared as equivalents to ASHA. Both the Andhra Pradesh and Jharkhand programmes have basic features of Mitanin programme with innovations in selection and training of the CHWs.

2006: Task force on the National Rural Health Mission's ASHA programme, finalises recommendations, printed as ASHA Operational Guidelines. They are further developed with guidelines for supportive structures.

2007: The XIth Five Year Plan (2007-2012), (Volume 2) commits explicitly that "Home-based neonatal care will be provided, including emergency life saving measures".

Development of the concept and its practice in civil society led initiatives

1. Comprehensive Rural Health Programme, Jamkhed- 1970 till present: One of the first projects to establish that women community health workers can bring about major improvements in core health indicators. A fairly rounded integrated approach, in about one lakh population, where community participation and multi-sectoral intervention were central to the effort, with a base hospital run by the NGO providing support.

2. CHW programmes by FRCH in Parinche, Maharashtra, IHMP, Pachod, Maharashtra, by RUHSA in Vellore, Tamil Nadu, by CINI in South 24 Paraganas, West Bengal, by SEWA- Rural in Jhaagadia,Gujarat and many others implemented between 1975 to 1995. Mostly similar to the CRHP, Jamkhed, each one of them demonstrate that women with little or no formal education, but with good training and support can provide a number of community level interventions: preventive and curative, and across sectors, that could lead to substantial measurable improvements in health. All these programmes tend to be parallel to the existing public health system in a limited number of villages with a referral support hospital of their own.

3. SEARCH, Gadchiroli, Maharashtra; Established in 1988. Initially a demonstration on how home based care by women community health volunteers could save child lives through early identification and antibiotic treatment of acute respiratory infections. Then went on to show substantial reductions in neonatal mortality through home based newborn care. Programme replicated through NGOs across many village clusters in Maharashtra. Important contribution was to develop protocols and methodologies of training and focussed health care provision by community health workers.

4. Arogya Iyyakkam 1995 to 2002: Tamil Nadu Science Forum (TNSF), Tamilnadu, and Arogya Sathi by CEHAT, Pune develop community health worker programmes, with the notion of a health activist. These programmes defined the CHW role as a combination of the community level care provision the rights activist role. Instead of being parallel to the public health system, and supported by an NGO run base hospital, the CHW focused on the public sector health facility to make it more responsive as a referral care provision site.

5. Jan Swasthya Sahayog: 2002 to present: The focus of this model is on a health facility providing a good quality of primary and secondary level care, linked to a health worker programme. The CHW component is organised more as an outreach service, rather than as a primary intervention.

   The ASHA programme design is thus rooted in this history of both government and civil society led programmes, and is enriched through learnings from all of these. The notion of effective community level care provision is from the NGO run CHW programmes, its focus on child survival is from the Gadchiroli programme, its rights activist framework and public system strengthening linkage reflect the NGO programmes of the late nineties. The particular combination of roles and the strategies of scaling up state-wide are from the Mitanin programmes. The so called failures of the 1978 (CHW), 1981(VHG) and 1995 (JSK- Madhya Pradesh) programmes are also an important part of the history; and though there is much debate and disagreement on why exactly they failed, this debate in itself has been instructive. This old debate can be re-visited in the light of this current evaluation study and its reflections on programme theories.

Table 2: Number of ASHA and population coverage

State	Targeted number of ASHAs	Total Number of ASHAs selected	Population coverage
Assam	29693	28798	One per revenue village (1:880)
Orissa	41102	40932	One per AWC (1:1007)
Kerala	32854	31868	1:764 population
Rajasthan	48372	43789	One per AWC (1:1062)
Andhra Pradesh	70700	70700	1:829 population
West Bengal	60984	30114	1 per 1000 population
Bihar	87,135	72,000	One per 1000 population (1:1006)
Jharkhand	40,964	40964	One per 500 population (1:514)

The number of ASHAs in all the states country-wide is given in annexure 3.

II. Management and Monitoring Structures for the ASHA Programme

National programme guidelines laid out the contours of a management cum support structure for the ASHA. This was in recognition of the fact that predominant among the factors underlying the failure of earlier large scale community health workers programmes in India was the lack of adequate support, mentoring and supervision. It also drew from successful community health worker NGO led programmes where some of the essential ingredients of success were the presence of intensive and constant mentoring and support, strong monitoring systems and supportive supervision.

The ASHA guidelines were disseminated to the states to serve as a basis for implementation. The document provides guidance on a range of topics: roles and responsibilities, selection, institutional arrangements, convergence with the Anganwadi Centre and with the ANM, working arrangements, training, compensation, monitoring and evaluation and financing of the programme. States were free to adapt the guidelines to their specific state context.

At the national level, the management of the ASHA programme was located within the Training Division of the MoHFW, supervised by the Joint Secretary (Policy), with oversight and guidance from the National ASHA Mentoring Group. The National Institute of Health and Family Welfare (NIHFW) provided support for the training, particularly the training of state trainers.

In December mid 2006, the National Health Systems Resource Centre (NHSRC) was created to provide technical assistance to the NRHM at national and state levels. Since mid 2007, NHSRC serves as the secretariat for the National ASHA Mentoring Group, provides technical support to the states for the ASHA and community processes programme through state facilitators, and supports the Training Division at the MoHFW on policy and operational issues.

At the state level the programme is expected to be led by the Mission Director, supported by an ASHA Resource Centre, created for this purpose. Policy guidance and programmatic oversight and some level of technical support are expected to be provided by a specially constituted State ASHA Mentoring

Group, consisting of NGO representatives, academicians, training institutions and research organisations. At the district level, a unit of a District Mobiliser/ Coordinator supported by an Accounts/Data assistant is expected to manage day to day functioning at the district level and liaise with the state ASHA Resource Centre. At the Block level, a Block Community Mobiliser with the aid of ASHA facilitators (appointed at a ratio of 1:20 ASHA) are expected to provide on site support supervision and review of the programme at the ASHA level. This level of management support was considered to be critical to the processes of selection, training, support and monitoring of the ASHA and other community participation programmes.

Table 3 shows the state of the management structure in these eight states. The table clearly reflects that in most of the High Focus states, the support structures were set up much after the ASHA were selected and training initiated. Orissa was the first state to establish the State and District support systems in 2008. Block and sub block support is provided through existing mechanisms, although they are expected to focus on the ASHA. This is also the situation in Jharkhand. The stipulated structure is in place only in Assam

In most of the High Focus states, the support structures were set up much after the ASHA were selected and training initiated. Orissa was the first state to establish the State and District support systems in 2008.

Table 3: Status of support structures programmes in the states

State	State level support structures	District level support structures	Block/sub block level support structures
Assam	NRHM State ASHA Programme Manager Located in NRHM state Programme management, supported by the State ASHA Resource Centre- outsourced to Don Bosco Institute, for state level training since 2009	One District Community Mobilise (DCM) and one assistant DCM, per district (since 2009)	NRHM Block Programme Manager, *One ASHA facilitator per ten ASHA, since 2009*
Orissa	Community Processes Resource Centre (CPRC), 2008 – located as five member sub-unit of state programme management unit	One District ASHA Coordinator per district; 2008	One contractual Block Programme Organiser and a Sector in charge, for all NRHM especially ASHA. (2009)
Kerala	Three member team for ASHA programme, within newly constituted State Health Systems Resource Centre. (since June 2010)	None, support and supervision through DPM/ CMO	None, support and supervision through ANM/LHV as an additional task.
Rajasthan	In 2007 State ASHA RC, outsourced to Adult Education Centre, moved to SIHFW in 2009, Now three member team for ASHA programme, within newly constituted State Health Systems Resource Centre (2010)	One District ASHA co-ordinators per district (2009)	Block ASHA Facilitators in place; (2009) PHC *ASHA Supervisors at sector level (2009)*

State	State level support structures	District level support structures	Block/sub block level support structures
Andhra Pradesh	None now -Initial 30 day training was outsourced to NGO-Academy of Nursing Studies	None, support and supervision through regular staff as additional charge	None, support and supervision through ANM/LHV as additional charge
West Bengal	None now-initial training rounds were led by CINI-RRC and organised through MNGOs.	None, support and supervision through DPM/ CMO	None, support and supervision through ANM/LHV as additional task
Bihar	State ASHA Resource centre (established in 2010), One project manager, and deputy project manager	District Community Mobilisers, (Oct 2010)	Block Community Mobilisers (Oct 2010). No ASHA facilitators.
Jharkhand	Village Health Committee-Sahiyya Resource Centre, (VSRC), 2008, before that Sahiyya Working group, (2005)	One District Programme Coordinator per district for Sahiyya (2009)	Initial one year through NGOs. Now only through existing structures as additional work. A block training team is in place.

and Rajasthan. In Rajasthan the State ASHA Resource Center has been moved from institution to institution and is yet to stabilise and provide leadership to the structures below. Bihar set in place the structures late in 2010 and it is yet too early to comment. Of the non high focus states, only Kerala has a team at the State ASHA Resource Center to monitor and manage the programme. Andhra Pradesh and West Bengal have yet to set up such structures and continue to manage with existing structures. It is commonly held that involving NGOs in programmes that need active community participation are likely to yield better results. The ASHA guidelines stipulate the role of NGO both in the institutional arrangements and in the sections of training. Involvement of NGOs has however been very limited. Kerala and Bihar did not involve NGOs in the programme at any level. In West Bengal and Andhra Pradesh the role of NGOs was restricted to training the ASHAs. In Orissa and Rajasthan there was some involvement of NGOs- but largely in the form of providing logistics support to training. In Jharkhand they were part of the Sahiyya Resource Centre. Initially the programme management had been outsourced to NGOs in the initial set of blocks taken up but because of dissatisfaction as well as poor support to this arrangement, that was abandoned after two years.

Establishing a management and support structure has been weak in all states studied. At the time of the interviews, only Assam had done so. Even Assam clearly needed much more capacity building of its facilitation teams. Orissa needed to put in place the sub-block ASHA facilitator – it had the rest in place. Rajasthan had all structures in place, but all of it needed more content, depth and skills to be effective. Orissa had the most functional review process in place, with a clear schedule of meetings and some mechanisms of recording and measuring progress. In contrast Andhra, Kerala, and West Bengal had no full time support structures in place at any level. This bleak scene is ameliorated by some favourable factors. Andhra Pradesh had a more motivated DPHNO – though despite this, it was perhaps the most weakly

monitored and supported ASHA of the eight states studied. Kerala had a good schedule of meetings and the ANM (called JPHN) was much more available for playing this role-as her work had either shifted up to the PHC or been shifted down to the ASHA-making her a supervisor of an ASHA with little work outputs of her own. And in West Bengal, Panchayat and field functionaries formed a viable administrative support team, though this was of little use to provide clinical support.

Many of the weaknesses of the ASHA programme can be traced back to this weak support structure.

Much of the weaknesses of the ASHA programme can be traced back to this weak support structure. The guidelines are explicit on this but that did not prevent this from being not followed and some state officials pointed out that even at the centre there was little follow up for this aspect of the programme. Details of state wise support structures are in Section 1a of Part 2.

III. Political and Administrative Leadership of the Programme

This section reviews the findings on the political and administrative leadership provided at the state level and the context of the governance environment in the state. Poor governance affects programmatic outcomes of the ASHA, not only through poor management of the ASHA programme itself, but also through the lack of effectively functioning outreach services and facility (infrastructure, human resources and supplies) care. Overall higher political commitment was reflected in the willingness to create institutional structures, and insist on a rapid programme rollout on key parameters such as training, creative managerial thinking and a deeper engagement of the leadership with the programme on the ground. In Assam a stable leadership at state level and a dedicated technical agency have served the programme well. This is also seen in Orissa where there is high political commitment to the programme. In West Begnal, Kerala, and Andhra Pradesh while there is commitment to the ASHA programme this is not reflected in the management or support or realised in terms of outcomes. In Rajasthan, Bihar and Jharkhand, frequent leadership changes have hampered programme progress. Statewise details on this aspect are in Section 1b of Part 2 of this report.

Poor governance affects programmatic outcomes of the ASHA, not only through poor management of the ASHA programme itself, but also through the lack of effectively functioning outreach services and facility (infrastructure, human resources and supplies) care.

IV. Training Curriculum and Training Strategies

The national guidelines stipulated that all ASHAs must receive 23 days of training in the first year and 12 days of training every subsequent year thereafter. This implies that by now in the EAG states the ASHA should have completed over 60 days of training, if the training had begun from FY 06. In practice most ASHAs have received anywhere between 15 and 25 days of training.

The general approach to training was to train state teams, which would train district training teams which would train the block level trainers of ASHAs and in the block or a sub-block centre the ASHA would be trained. For the first four modules the state teams were trained at NIHFW, Delhi and for the fifth they were trained at the state capital, by the national training team with the assistance of an NGO-CHETNA.

The curriculum of the training was to achieve the roles and responsibilities as set out in the ASHA guidelines and the terms of reference of the National ASHA mentoring group was to develop these modules. In practice the modules were developed by one or two technical officers of the Ministry in coordination with UNFPA for the first module and even without that subsequently. The fifth, sixth and seventh modules were however developed under guidance and with inputs from the ASHA Mentoring Group.

A description of the training curriculum is given below in Table 4.

Table 4: Content of the modules

Training modules for ASHA	Topic	Knowledge	Skills
Module 1 Introduction	1–17 Introductions to NRHM, to ASHA tasks, ASHA training, to health, to hygiene, to healthy food, water safety, to waste water, to body, to women and health, to health centre, to Anganwadi centre, to illness, birth attendant, to remedies, to home remedies. 18-19 – unwanted pregnancies, condoms 20-21. pregnancy registration and JSY 22–24 – immunisation, breastfeeding, infant nutrition. 25–27. Aches and pains Snake bite, Diarrhoea, 28 & 29, TB, HIV and AIDS	1. Awareness on all issues 2. Importance of breastfeeding 3. Signs of dehydration and management of diarrhoea-when to refer 4. Suspecting TB 5. Signs of venomous snake bite-and first aid for the same	Nil-not even how to make home ORS-though this is recommended. Features of dehydration are written as knowledge – not as a skill to learn-though referral for dehydration is a task. Snake bite messages are adequate.
Module 2 Maternal and Child Health	1. Menstruation and fertility 2. Care during pregnancy 3. Care in delivery and post-partum 4. Newborn care 5. Unsafe abortions 6. Immunisation 7. Diarrhoea 8. ARI 9. Nutrition 10. Fever	1–5 are broad messages-at level of common sense/existing knowledge of an 8th class pass. 6 Immunisation schedule in some detail-adequate information. 7–10 – common sense knowledge-less than in book 1 and grossly inadequate to achieve even referral.	How to take temperature
Module 3 Family Planning, HIV/AIDS and ARSH	Benefits of small family norm. Details of each method-including the cervical mucus method. RTI-STI-HIV Menstrual hygiene.	General information on each method of FP. Recommends that ASHA can start a woman on OCPs	
Module 4 National Health Programmes, AYUSH, and management of Minor illnesses and first aid for burns	1. TB 2. Malaria 3. Dog and animal bites 4. Burns 5. Wound care- 6. Homeopathic drugs that can be given for anaemia, diarrhoea, nausea and vomiting 7. Some AYUSH home remedies	Awareness level – less than given in book 1 for TB Useful first aid tips in 3 to 5. Long list of homeopathic drugs-difficult to remember or obtain!!	
Module 5	Leadership and Women Empowerment	Health activist role Understanding human and fundamental rights Understanding the meaning of right to health	Leadership, Communication, Negotiation and Coordination skills

The strength of the first four modules is that in touches on every topic that is mentioned in the roles and responsibilities. Therefore it legitimises the teaching of these topics.

The weakness of these first four modules is that in almost every topic the information is incomplete and insufficient for the ASHA to undertake any action, even referral action. Much of the syllabus, especially in the first module, but also in all the others is spent on generalities-or "awareness" as it is often referred to. Most VIII class students would know much of these; e.g. clean your teeth regularly, or if there is bleeding during pregnancy visit the doctor!! But where early referral would make a difference, there the information is inaccurate and incomplete. For example the ASHA is told to refer a child to First Referral Unit with ARI if it has "fast breathing" or "difficulty in breathing." This is the only reference anywhere to the knowledge and skills needed for differentiating trivial coughs from pneumonia. Any child with a cold with or without mild fever would qualify and certainly for every cold they cannot rush to the distant FRU which is what the advice is!! The second module actually makes an effort and even decreases the content on the same topics from Module-1 except for immunisation, which is surprise for progression across books is usually upwards. The same can be said for danger signs of post partum care, newborn, care, dehydration in diarrhoea as given in book Module-2. In complementary feeding in Module-2, the messages are inadequate – not even the addition of fats and oils or greens and reds, or any notion of quality or quantity in complementary feeding is missing.

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Some questions arise from examining these texts: Was there a policy decision at some level of implementers at some point of time to limit the ASHA only to promoting women and children for institution delivery and attend immunisation day – for then these modules would be sufficient. Not even changes in health behaviours are being promoted. The usual practice is to use subsequent modules to upgrade skills. The downgrading of knowledge levels from Module-1 to Module-2, even on nutrition and breastfeeding, is therefore quite curious. Or was it just inadequate skills and experience in community health work amongst the authors of the latter modules? Or was it an informal decision to "dumb down" the ASHA to a more modest level of knowledge. Or could it be that Module-2 was written without reference to Module-1? Or a bit of all of the above?

The weakness of these first four modules is that in almost every topic the information is incomplete and insufficient for the ASHA to undertake any action, even referral.

And an even more interesting research question-how is it that when tested for knowledge and skills in the ASHAs, they were able to answer much better than the modules teach at least on a substantial number of questions. Examples of such knowledge levels-included chest in drawing as a sign of pneumonia (45% - range 30 to 69%), (foul-smelling vaginal discharge as a danger sign of post partum period (26% range 18 to 37%), continuing to feed a child with diarrhoea (33% range 43.5% to 1.5%). The numbers in the brackets indicate the % of ASHAs who answered correctly – the highest state score, the lowest state score are given as the range, and the modal score – average of the 4th and 5th ranked state score is given as the overall number. Of course only some of the ASHAs knew the answers, but even these modest levels are a big achievement, since these essential messages are not in the text of the training materials. In contrast there are a number of essential messages which are only mentioned in passing, which do not

get stepped up during the cascade: For example on the desirability of adding fats and oils in complementary feeding the level of correct ASHA response could be averaged as 21% (with a range of 0.5% to 43.5%) – which is as expected because there is no message on this in Module 2 and Module 1 mentions it very lightly-almost in passing. Need for weighing the newborn child has a range of 18% to 72% – with an average at 41%. On not giving a bath to the newborn-the range is from 18 to 66 with the median state having a 34% score. Similarly drugs to be given for suspected malaria is low, even in high malaria districts. There are a third set of messages-which are well emphasised in the training material and which have been (therefore!) transmitted adequately – these relate to referral to government facility for a complication in pregnancy, early initiation of breastfeeding and duration of exclusive breast-feeding, prevention of diarrhoea through hand washing, giving ORS for diarrhoea, referring any child with ARI etc, need to give immunisation (knowledge on exact vaccines given at each month could be much lower), need to get sputum tested in chronic cough, contraceptive choice etc. Of course even in these knowledge elements there is a range and some of the states like Bihar and Jharkhand would have only 65 to 70% of ASHAs being able to tell the correct choice for spacing or delaying the first child.

The received wisdom is that in a training cascade, there is considerable loss of information content down the cascade and evaluation usually interprets training outcomes based on this assumption. That assumption may not be appropriate for this programme.

How do we explain this variation? We know that some states like Jharkhand and even West Bengal substantially strengthened the message content-Jharkhand even revised the modules entirely, made it more pictorial and more key information rich. (ASHA scores on a wide variety of knowledge areas are higher than Assam – which had a far better supported programme). We know that states like Rajasthan and Uttar Pradesh and Angul in Orissa supplemented these modules with child health modules of their own and Kerala supplemented it with messages on non communicable disease. We know states like Andhra Pradesh never introduced these modules at all. But to what extent did those modules do better has not been assessed. Even where these national modules were used as such, like in Orissa and Assam, the levels of knowledge found in the study is certainly more on some parameters than what is available in these rather information sparse training material. The received wisdom is that in a training cascade, there is considerable loss of information content down the cascade and evaluation usually interprets training outcomes based on this assumption. That assumption may not be appropriate for this programme. What we see is a pattern of step up in transmission at different levels, but since these were largely spontaneous and varied across states and districts, the net outcomes in knowledge and skill levels also vary. Residual knowledge and diffusion of important messages and knowledge transmitted during review meetings may also have helped. Also it follows clearly that most, if not all the knowledge gaps identified in the training programme must be related primarily to this training material, rather than loss during training and therefore the effort should be to close the gaps in subsequent training gaps. The training design also does not seem to have internalised the difference between knowledge and skills, and the way skills are imparted different from knowledge.

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The only skill that is imparted in the first four modules is the skill to take temperature using a thermometer where the steps are spelt out in some detail-but no method of imparting it as a skill is indicated. The lack of a separate trainer's manual may be a major reason for this. All these four modules are

only reading materials for ASHA. Trainer modules were never written for two to four. For Module 1 it was developed but had not been used in most of these states. There are other skills-like identification of dehydration which in Module 1 is introduced adequately as a knowledge element and which an accompanying training module or CD could have converted into a skill-but that has not happened. Other skills like recognising signs of pneumonia are sub-critical even as knowledge.

Part of the problem could be that training of community health workers has not been recognised as requiring its own set of technical requirements with necessary experience and skills. Medical professionals who have not actually worked with community health workers training would not be able to imagine these requirements, even if they were conscious of the need to do so.

In contrast Module 5 was developed by a non governmental organisation with experience in community health worker and reviewed and improved upon by the ASHA mentoring group. There is both a reading material and a facilitator's guide for training on the module. Its reception has been much better. However the roll out of training in Module 5 has been much slower.

States adopted varying training strategies and statewise details are provided in Section 1c of Part 2 of this report.

Did education level correlate with better knowledge and skills? We looked for statistical correlation between whether an ASHA is at least 8th class pass and her knowledge of

a) Foul-smelling discharge as an important sign to look for in the post partum visit.
b) Colostrums feeding, early initiation of breast feeding and keeping the baby warm were important messages to deliver.
c) Steps in making ORS.
d) Chest in-drawing as a danger sign to look for in a child with acute respiratory infection.
e) Vaccine given in the ninth month protects against measles.
f) Blood slide to test for malaria has to be made in woman suffering with fever and chills.
g) IUD as a preferred method of spacing for a woman who is breastfeeding an young child.

The questions chosen for statistical correlation with educational level were those that was beyond common sense knowledge- like heavy bleeding as a danger sign, and where there was some variation in results across the districts studied. If everyone did not know- or if over 90% of ASHAs knew the answers then obviously the training or lack of it was the determining factor and would not compensate for the educational level.

We found that in no district was there a correlation on all seven knowledge questions. In the districts of Dibrugarh and Karimganj in Assam, in Trivandrum and Waynad in kerala, in Bhirbum and Malda in West Bengal, in Angul in Orissa, in Khammam of Andhra Pradesh. educational

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level was not associated with outcomes at all- even in Karimganj and Khammam where considerable relaxation of age criteria had been exercised. In Bundi in Rajasthan and in Nayagarh the more educated could recognise the danger sign in ARI better (p = 0.037; 0.048) and in Banswada (p = 0.034) they knew the correct answer to vaccine given in the ninth month. In East Godavari – on only one parameter – was there a significant association- the process of making ORS (p = 0.044). In both districts of Bihar there was one question in each on which analysis showed a correlation- making blood slides for malaria (p = 0.025), and danger signs of the post partum period (p = 0.009). In Dhanbad alone where over 35% of ASHAs were educated less than 8th class- the level of knowledge of ASHA was positively associated with better knowledge of ORS (p = appropriate spacing method and danger signs of post partum care.

A similar pattern can be seen in training duration- where the correlation was again with these very same seven parameters, and again only in one of the seven questions and in seven of the 16 districts did longer duration of training lead to better knowledge levels. Quality of training matters, but duration of training would not matter as with more days of training – more topics are covered- and there is little measurement of knowledge levels and re-training to achieve these levels which is ongoing.

We could conclude that the basic level of education did not have a significant correlation with knowledge levels in all district studies, except to some extent in the district of Dhanbad. It is possible that more educated women have a better background knowledge of some health issues- like making blood slides for fever in malaria or on preparation of ORS and therefore perform better – but it is certainly not due to a capacity to absorb information from the books and training programmes better. And that mere longer duration of training is not also the determinant of knowledge. It is the quality of training which includes how the messages are highlighted in the training material, the transaction of the manuals and most important training evaluation that determines knowledge outcomes.

Many states have innovated on training modules and on training programmes and final outcomes of training are encouraging.

One of the main weaknesses in the training programme is the content of the training modules-especially of training Module 2 – which covers a wide number of vitally important topics in too incomplete and superficial a manner and does not even have a trainer guidebook accompanying it. Training module design has had a weak understanding of competency based training. This may be also because of a strong motivation of shaping an ASHA who is effective as an agent of promoting immunisation and institutional delivery, but not as one who would have skills for provision of health care or change of health care practices.

Despite this limitation, many states have innovated on training modules and on training programmes and final outcomes of training are encouraging. Where the modules are effective, the training outcomes are adequate but such areas are few. In some areas ASHAs have better skills and knowledge than in the training design, but because this is based on spontaneous corrective measures and improvements the pattern of such better knowledge is patchy and broadly conforms to those messages which are more prevalently and popularly known.

Table 5: Training status (Phase 2)

	Less than or equal to 10 days	11 to 15 days	16 to 22 days	23 days	24 to 30 days	>30 days	NA
Kerala	**0**	**46.5**	**51.5**	**0**	**1**	**0**	**1**
Trivandrum	0	30	67	0	2	0	1
Wayanad	0	63	36	0	0	0	1
Orissa	**3**	**1.5**	**32.2**	**6.5**	**35.2**	**11.6**	**10.1**
Nayagarh	5	1	9	1	53	15	16
Angul	1	2	55.6	12.1	17.2	8.1	4
W. Bengal	**0.5**	**0**	**2.2**	**78.8**	**7.6**	**1.1**	**9.8**
Malda	1	0	4.1	72.2	14.4	1	7.2
Birbhum	0	0	0	86.2	0	1.1	12.6
Assam	**6.9**	**14.3**	**50.3**	**7.4**	**15.9**	**3.2**	**2.1**
Dibrugarh	12.4	17.5	44.3	5.2	15.5	2.1	3.1
Karimganj	1.1	10.9	56.5	9.8	16.3	4.3	1.1
Rajasthan	**6.5**	**24.6**	**31.7**	**8**	**23.6**	**5**	**0.5**
Banswada	13.1	39.4	28.3	1	15.2	2	1
Bundi	0	10	35	15	32	8	0
AP	**5.3**	**0**	**34.7**	**1.6**	**31.6**	**10.5**	**16.3**
East Godavari	6.5	0	28	1.1	46.2	3.2	15.1
Khammam	4.1	0	41.2	2.1	17.5	17.5	17.5
Bihar	**87.1**	**10.2**	**0**	**0**	**0**	**0**	**2.7**
Khagaria	88.8	6.7	0	0	0	0	4.5
Purnia	85.6	13.4	0	0	0	0	1
Jharkhand	**50.8**	**41.6**	**0.5**	**0**	**0.5**	**4.3**	**2.2**
Dhanbad	37.4	54.5	0	0	1	5.1	2
W Singhbhum	66.3	26.7	1.2	0	0	3.5	2.3

The pace of training has been poor and this relates almost directly to the amount of training human resource for training that has been deployed either possible to spare within the system, like in Kerala, or sourced in from NGOs like in Assam and Orissa or early in the programme in Andhra Pradesh and Jharkhand, or recruited full time-again like in Assam or Orissa. Where it is based only on internally available, already busy staff, the training programmes have languished. Training evaluation has also not been conducted in most states.

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V. Incentive Payments: Patterns and Perceptions

National guidelines for ASHA lay out that she is intended to be a "honorary volunteer" but would be compensated for her time in specific situations (such as training attendance, monthly reviews, and other meetings). In addition she would be eligible for incentives offered under various national health programmes and also could be compensated out of the untied funds at the VHSC for specific outcomes. In general all states incentivise the ASHA for JSY and immunisation and participation in review meetings. Different states have however evolved varying guidelines for ASHA incentives for various other

Table 6: Incentives received by ASHAs- cumulative of last 3 months

	Less than Rs. 150	Rs. 150-500	Rs. 501-1500	Rs. 1500-3000	Rs. 3001-5000	More than 5000
Kerala	**0**	**0**	**23.9**	**55.7**	**19.9**	**0.6**
Trivandrum	0	0	20.7	42.5	36.8	0
Wayanad	0	0	27	68.5	3.4	1.1
Orissa	**0**	**3.5**	**8**	**25**	**39**	**25**
Nayagarh	0	7	14	33	35	10
Angul	0	0	2	16	43	39
W. Bengal	**0**	**0**	**0**	**100**	**0**	**0**
Malda	0	0	0	100	0	0
Birbhum	0	0	0	100	0	0
Assam	**3**	**1.5**	**10**	**27**	**36**	**22.5**
Dibrugarh	3	1	12	24	39	21
Karimganj	3	2	8	30	33	24
Rajasthan	**2.3**	**2.9**	**37**	**50.9**	**6.9**	**0**
Banswada	2.3	2.3	55.2	35.6	4.6	0
Bundi	2	3.5	19	66	9	0
AP	**9.5**	**1.5**	**45.5**	**43.5**	**0**	**0**
East Godavari	19	3	76	2	0	0
Khammam	0	0	15	85	0	0
Bihar	**20**	**11**	**22**	**15**	**16**	**17**
Khagaria	34	12	15	10	14	14
Purnia	4	9	29	20	18	20
Jharkhand	**27**	**11**	**24**	**29**	**4.5**	**5**
Dhanbad	43	16	23	7	6	5
West Singhbhum	11	5	25	50.5	3	5

activities such as – cataract, family planning DOTs, malaria slides, support in water and sanitation programme. These guidelines are updated annually and vary from year to year and state to state.

This mode of performance based payment is followed in Orissa, Assam, Jharkhand, and Bihar. In Rajasthan a blended system of payment is followed, with a flat payment of Rs. 950 topped by performance incentives. Rs. 500 of this is from the WCD and Rs. 450 is from the state health department. In the non high focus states, Kerala follows the performance based incentive structures, West Bengal providing a fixed monthly emolument (calculated based on an approximate number of cases in the population of 1000 and compensation in case of a performance based payment system) and Andhra Pradesh a performance based payment which in certain areas was blended with a fixed Rs. 400 per month.

Clearly the experience of payment varies widely across states-as can be seen in the graph. Even with states or within a group of ASHAs it could vary widely. Assam, Orissa and Kerala are purely performance based with robust mechanisms of accounting and timely payment. West Bengal has a fixed amount system which is well implemented. The ASHA is quite functional-but as we shall see later the link with the JSY as the main focus of her work is clearly lost.

Table 7: Mode of payment

	Cheque	Cash	Bank transfer	NA
Kerala	**4**	**87.5**	**0**	**8.5**
Trivandrum	7	78	0	15
Wayanad	1	97	0	2
Orissa	**29**	**15.5**	**74.5**	**5**
Angul	9	9	89	3
Nayagarh	49	22	60	7
W. Bengal	**0.5**	**96.2**	**0.5**	**3.3**
Malda	0	94.8	0	5.2
Birbhum	1.1	97.7	1.1	1.1
Assam	**65.5**	**76**	**23.5**	**1.5**
Dibrugarh	35	81	47	2
Karimganj	96	71	0	1
Rajasthan	**88**	**34**	**17**	**1**
Banswara	97	37	13	0
Bundi	79	31	21	2
AP	**54**	**45**	**2**	**3**
East Godavari	35	60	3	4
Khammam	73	30	1	2
Bihar	**11.5**	**61**	**27**	**3.5**
Khagaria	7	89	0	4
Purnia	6	33	54	3
Jharkhand	**40.6**	**31**	**0**	**28.4**
Dhanbad	18	40	0	42
West Singhbhum	63.9	21.6	0	14.4

Rajasthan has a fixed payment system which is poorly implemented-but the loss of efficiency in JSY referrals may be more due to contestation over who gets the incentive than the loss of the performance based linkage. Andhra, Bihar and Jharkhand have performance based payments which are poorly implemented – clearly co-relating with the lack of a management-support structure in these three states. In Andhra Pradesh and Kerala, the problem is compounded by JSY being a poor yield opportunity as only BPL women get the JSY package and anyway fertility rates are much less.

Mode of payment has a role-but there is no clear relationship between the level of payment and mode. In Orissa, bank transfer was the major mode, in Assam and Rajasthan it was a mix of all three-bank transfer, cheque and cash, in Jharkhand and Andhra Pradesh it was a mix of cash and cheque and it was cash predominantly in West Bengal, Kerala and Bihar (Table 7). Additional details on payment for the individual states are in Section 1d of Part 2.

Mode of payment has a role-but there is no clear relationship between the level of payment and mode.

VI. Drug Kits: Supply and Replenishment

A drug kit is also expected to be provided to the ASHA. The GOI issued model guidelines to streamline refilling of the ASHA drug kit. The contents of the kit were a part of the guidelines, but states have adapted the list in

Findings from Phase 2 demonstrate that where the ASHAs are supplied with drug kits and regular replenishment is being done, both ASHAs and beneficiaries report the use of ORS for management of diarrhoea. This indicates that where ASHA is equipped with the necessary drugs there exists a high potential to manage childhood illnesses at the community level.

ASHA Drug Kit as per guidelines and manuals

- ORS
- Paracetamol
- Oral Contraceptive Pills
- Condoms
- IFA
- Cotrimoxazole
- Chloroquine
- Dicyclomine
- Albendazole
- Nischay Kit
- Thermometers
- Bandages
- Cotton Swab
- Betadine
- Gentian Violet

many cases. The kits are expected to be filled monthly, with the ASHA being given a stock equal to a three month requirement the first time. A drug kit stock card has also been provided. Except in Bihar the drug kit has been provided to all ASHA. Even when the kit has not been provided, ASHA are given some drugs to be dispensed. The major issue is timely replenishment. There is also a sense of unease among medical officers about the possible wrong use of drugs, versus the potential advantages of providing first contact care. This sense of ambiguity perhaps manifests itself in limited attention being paid to training in the use of the drug kit and de-emphasising its use, which can lead to wastage of supplies and lower priority paid by ASHA to provision of first level curative care. Findings from Phase 2 demonstrate that where the ASHAs are supplied with drug kits and regular replenishment is being done, both ASHAs and beneficiaries report the use of ORS for management of diarrhoea. This indicates that where ASHA is equipped with the necessary drugs there exists a high potential to manage childhood illnesses at the community level. The findings demonstrate that even where drug kits are available and replenished, systems still need strengthening to ensure that ASHA are equipped at all times with life saving drugs such as chloroquine and ORS. More details for each state are in Section 1e of Part 2.

VII. Financing of the ASHA Programme

With this set of revised guidelines, the amount allocated per ASHA was increased to Rs. 10,000 per year. The original amount of Rs. 7415 was left unchanged and the additional amount was budgeted for support systems.

The financial guidelines for the ASHA programme were initially laid out in the Accredited Social Health Activist guidelines[5], issued by the Ministry of Health and Family Welfare in July 2006. The financial norms for an ASHA, included costs incurred on selection processes including social mobilisation, training, drug kit and untied funds to the village and amounted to Rs. 7415 per ASHA. The guidelines also stipulated that the incentive payments would come from the various programmes and thus were not part of this amount. In October 2006, a supplementary set of financial guidelines were issued by the MoHFW to make provision for a support structure from state to sub block levels, and for the supply of identity cards, bags, and badges for the ASHA. With this set of revised guidelines, the amount allocated per ASHA was increased to Rs. 10,000 per year. The original amount of Rs. 7415 was left unchanged and the additional amount was budgeted for support systems.

As against these norms, information on funds released and expenditures incurred for financial years 2005–06 to 2009–10 are provided in the table below. Not unexpectedly, expenditures were lower in the early years, given that

5 Accredited Social Health Activist Guidelines, (ASHA), Ministry of Health and Family Welfare, Government of India.

states were in the process of establishing the institutional and programmatic structures for NRHM as well as the time taken for start up of the ASHA component. In the three functional years since then, states ought to have spent about Rs. 30,000 per ASHA.

Based on the figures for the expenditure of funds per ASHA since 2005–2010, the states can be grouped in to three categories. a) States with high expenditure figures – Assam, Orissa and Kerala; b) states with moderate level of expenditure – Rajasthan, Jharkhand and West Bengal and c) states with low expenditures – Andhra Pradesh and Bihar. There is a close correlation between expenditures and performance on the ASHA programme. This classification also correlates to the level of support provided to ASHAs through – support structures, training, regular replenishments of drug kits and incentives paid to ASHAs.

The highest expenditure of all eight states is in Assam amounting to Rs. 12,546, and this correlates with a well performing ASHA programme, which has all support structures in place, and where training is largely on schedule and there is good political will to support the programme. It is still only one thirds of what the state should have spent. This is seen in the poor pace of the training programme and weak monitoring and supervision. It has developed both internal and outsourced additional management capacity for this task.

Orissa reports the second highest expenditures with about Rs. 10,689 per ASHA and is also linked to a strong ASHA programme on the ground. The support structures are not complete, but supplemented by deploying other NRHM contractual staff on the job. Training pace is similar to Assam, behind schedule-but ahead of other states. Orissa has developed adequate internal management capacity based on hired consultants and supplements its capacity for district level management by bringing in NGOs for logistic support in training.

Kerala expanded its programme late, but still has an expenditure of Rs. 10,689 per ASHA. This is a largely because of an adequate pace of training in the state. It is able to spare internal support for the programme, because of a less burdened JPHN, but it too has not built up much management capacity.

Rajasthan's estimate of Rs. 7529 over three years may be a serious under-estimate-as the state government spends almost Rs. 950 per month per ASHA extra on fixed honorarium. If based on the evidence we presume that the actual outflow is lesser and put it about Rs. 800 per month, it would still mean another Rs. 8000 per year or Rs. 24,000 over three years making it the highest expenditure amongst states. However it also provides performance based incentives. This Rs. 7529 is part of the Rs. 30,000 they should have spent on training and support and this expenditure is therefore still insufficient and reflective of delayed and weakly functional support structures.

West Bengal's Rs. 8300 is however not an over-estimate as the honorarium is only a re-packaging of performance based incentives from NRHM and not an additional expenditure. This gap between Rs. 30,000 and Rs. 8300 represents the slower pace of training and the lack of investment in support structures. Further in West Bengal, the ASHA has been selected and deployed in only half the state. If we compute the total expenditure on ASHA and not the sum per

ASHA, the state programme expenditure would be only about 12% of what the state was eligible for under this scheme.

Jharkhand has expenditure at Rs. 7348 per ASHA. Because it has deployed some additional management capacity in the form of NGOs at state level, and for some time at the district level, it has been able to do better than Bihar. But not much better. It still has a weak management capacity and a poor pace of training.

Bihar's expenditures of Rs. 3373 per ASHA is the lowest amongst the 8 states examined and it correlates with the weakest programme-where training is still to take off beyond the first round, and where there is no support structure in place. The ASHA herself, as we shall see, is limited in functionality to two focussed tasks with a very limited sense of the health practices she is meant to address and an even lower effectiveness. It neither has the management capacity to run the programme, nor the governance to add on additional capacity by recruiting NGOs or recruiting contractual staff.

In Andhra Pradesh expenditures appear to be low, but this is likely because all trainings had been completed before the ASHA programme was sanctioned

Table 8: Fund releases and expenditure (In crore)

		Andhra Pradesh	Assam	Bihar	Jharkhand	Kerala	Orissa	Rajasthan	West Bengal
2005–08	Fund released	0	14.55	31.89	28.78	0.57	24.51	25.43	0
	Expenditure	2.23	4.53	4.73	6.72	1.38	4.6	4.35	4.96
	% Expenditure over fund released		31.13	14.83	23.35	242.11	18.77	17.11	-
2008–09	Fund released	0	29.69	17.15	9.51		4.07	12.23	5.17
	Net Cumulative Fund available		39.71	44.31	31.57		23.98	33.31	0.21
	Expenditure	0.18	2.27	5.78	17.96	21.6	9.54	12.88	1.7
	% Expenditure over cumulative fund		5.72	13.04	56.89		39.78	38.67	809.52
2009–10	Fund released	8.5	29.69	56.03	8.56	21.17	27.9	41.5	5.72
	Net Cumulative Fund available	8.32	67.13	94.56	22.17	-1.24	42.34	61.93	4.23
	Expenditure	9.74	29.33	13.57	5.42	10.06	18.51	15.23	12.86
	% Expenditure over cumulative fund	117.07	43.69	14.35	24.45	-811.29	43.72	24.59	304.02
	No of ASHAs (as on April 10)*	70700	28798	71395	40964	30909	34252	43111	23518
	Fund Spent per ASHA, (in Rs.) FY 09–10	138	10185	1901	1323	3255	5404	3533	5468
Total: 2005–2010	Total Fund released	8.5	73.93	105.07	46.85	21.74	56.48	79.16	10.89
	Expenditure	12.15	36.13	24.08	30.1	33.04	32.65	32.46	19.52
	% Expenditure over total fund released	142.94	48.87	22.92	64.25	151.98	57.81	41.01	179.25
	Total Fund Spent per ASHA, (in Rs.)	1719	12546	3373	7348	10689	9532	7529	8300

Source: ROPs & PIPs. Expenditure data is presented as reported by states.

under NRHM. The poor annual absorption of funds also correlates with lack of support structures and other support activities, little investment in training quality. It has limited internal capacity for such a programme and like Bihar has a reluctance to engage with external technical resources, such as NGOs. or hire contractual staff.

In summary: All states have an expenditure on this programme which is much less than what is allotted. The primary reason for this low expenditure is the inability or unwillingness to invest in management and support structures at state, district and block levels. This is also reflected in poor pace of training and impacts the quality of training as well. Expenditure rates are also reflective of the quality of political and administrative support the programme as-the willingness to put their money where it matters.

The primary reason for this low expenditure is the inability or unwillingness to invest in management and support structures at state, district and block levels.

VIII. Village Health and Sanitation Committees (VHSCs) and Social Exclusion

Issues addressed in this section include the assessment of the Village Health and Sanitation Committees (VHSC), the effectiveness of ASHA in social mobilisation, and the experience of the ASHA and VHSC programme in enabling increased reach to marginalised groups. Section 1f of Part 2 of this report has detailed findings on VHSC and social exclusion for each state. VHSC have been formed in Rajasthan, Jharkhand, Assam, Andhra Pradesh and Orissa (referred to as Gaon Kalyan Samiti). In West Bengal, Kerala and Bihar the existing health and sanitation committees of the Gram Panchayats have been designated as the VHSC with differing nomenclature and modifications in membership. Thus the Gram Unnayan Samitis of West Bengal include SHG members and ASHA, the Ward Health and Sanitation Committees in Kerala work closely with the Kudumbashree or the network of SHGs, and in Bihar the existing Village Health Committees of the Gram Sabha have been designated as the VHSC. Table 9 provides information on the status of VHSC in the village and the ASHA's engagement with the VHSC.

A major challenge for the ASHA programme is to ensure equitable service delivery to all community members. This involves understanding issues of inequality and finding local contextual programmatic and implementation solutions. The Phase 2 evaluation explored the issues of establishment of Village Health and Sanitation committees and the role of the ASHAs therein. Specific questions were asked from ANM, AWW and PRI representatives on which communities received the most benefits from ASHA services. A key finding from this data is that while ASHAs are reaching a large section of the community they were not perceived as specifically prioritising marginalised household.[6]

A major challenge is understanding issues of inequality and finding local contextual programmatic and implementation solutions.

The evaluation studies what % of service users A were from the SC community and whether this was proportionate to the recorded percentage of

6 Marginalised communities were defined for the purpose of this evaluation as – SC/ST households, hamlets, houses of migrants, economically backward, households with disabled women, women headed households.

Table 9: Functionality of VHSC

States	% of ASHAs reporting functional VHSC in the village	Of those who reported a functional VHSC % of ASHAs reported being a member/ member secretary	Of those ASHAs who reported a functional VHSC % of ASHAs receiving support from VHSC	% Of ANMs who said there is a functional VHSC in their area
Kerala	**97**	**98.4**	**99**	**100**
Trivandrum	97	96.9	98	100
Wayanad	97	100	100	100
Orissa	**82.5**	**90.9**	**95**	**78.4**
Nayagarh	87	90.8	92	80.8
Angul	78	91	97.4	76
W. Bengal	**17.4**	**46.9**	**66**	**31.3**
Malda	12.4	33.3	75	33.3
Birbhum	23	55	60	29.2
Assam	**93.5**	**96.8**	**83**	**84**
Dibrugarh	94	97.8	89	80
Karimganj	93	95.7	78	88
Rajasthan	**77**	**86.3**	**83**	**87.3**
Banswara	70	85.7	90	87.5
Bundi	84	86.9	77	87.1
AP	**58.5**	**71.8**	**92.3**	**77**
East Godavari	86	74.4	95	91.5
Khammam	31	64.5	83.8	27
Bihar	**6**	**41.6**	**58.3**	**27.3**
Khagaria	2	50	50	18.5
Purnia	10	40	60	35.7
Jharkhand	**84.3**	**66.2**	**73.5**	**74.5**
Dhanbad	83	55.5	83.1	72
West Singhbhum	85.6	77.1	63.9	76.9

SC community in the district. In every one of the 16 districts it was definitely more. In two districts the difference was less than 10% more. But in the Andhra Pradesh districts as against 17% of SC in the districts – 42% of 48% of users were from the SC community. In contrast the districts of Rajasthan the difference was the least-percentage of users who were SC were about the same as in the population.

The same could be said about the ST community also-but in this instance in almost all districts the % of service users A who are ST is a modestly higher than the % of ST in that district.

Perceptions of ANMs and AWW on the existence of marginalisation is limited and much less than that of the ASHA and the general perception is that ASHA serves "everyone in the village" equally - no special concept of affirmative action to reach the weakest. More ASHAs in contrast report sections which have difficulty in accessing health services, as well as report sections that they have problems in accessing. These problems are also reflected in the poor

coverage of services-more so precisely in those districts where perceptions of marginalisation are less.

The VHSCs have been established in the majority of villages and this is confirmed by ANMs, AWWs, PRI members and ASHAs independently. PRI members assessment of the VHSC functionality is about half of the others estimate in Rajasthan (41%) but in other states it is about the same or at best about 10% less. and Where established it is generally supportive of the ASHA and usually the ASHA has an important role in this. But in West Bengal such a relationship is established only in one thirds and in Jharkhand in about 70%. VHSCs are not established in Bihar and the process has taken place in only about one fifth of the villages of West Bengal and half the villages of Andhra Pradesh.

Where VHSCs are established and functional, they are supportive of many health activities and functionaries, though there is much room for improvement especially in the key task of village health planning.

Where VHSCs are established and functional, they are supportive of many health activities and functionaries, though there is much room for improvement especially in the key task of village health planning.

IX. Framework of Understanding (Programme Theory) and Perspectives of Various Officials on the ASHA Programme

One of the many reasons why a programme does not get implemented as planned, is because programme managers also have strong views of how a programme ought to unfold. Different stakeholders have different explanations of how an ASHA's work would lead to improved health status; and what she should do; what she should be allowed to do and what she should not do. It is through this perceptual framework of understanding that they make meaning of the programme and its success or failure.

Questions under this head including asking programme officers at state, district and block levels, their perception on the role of ASHA, what motivates women to becoming ASHA, extent to which ASHA programme has contributed to strengthening the health programme in the state and the outcomes it is intended to achieve. In the non high focus states, an additional issue for investigation was the perception of various stakeholders on the need for ASHA, and whether there has been any attempt in casting a new role for the ASHA. Respondents to this set of interviews include State Mission Directors, Directors of Health and Family Welfare, District and Block Medical officers, and ASHA nodal officers at state, district and block levels.

Broadly the views expressed could be categorised into three frameworks of understanding also called "programme theories." There are high degrees of variation within and overlaps between these three categories. The first and most frequent category in use is where the ASHA is considered a facilitator, largely playing only two roles: promotion of institutional delivery and mobilisation of beneficiaries for the VHND. This we label the "***Link Worker***" understanding (Programme Theory 1 or **Framework of Understanding-1**). Since all three categories accept the link worker or facilitator role, this framework 1 is really distinguished by what the ASHA is NOT. ***ASHA is NOT a service provider.*** Any

form of disease identification or drug prescription is suspect. A very general health education often described as health awareness is permissible but active counselling is not welcome. Additional knowledge is seen as dangerous and more attention is paid to limiting her skills. There are three reasons given for this: (i) ASHA would become a quack and set up private practice, and given her level of skills this could be dangerous, (ii) this would lead to laziness of the paid staff, and (iii) and that she would demand to become a regular employee. ASHA in Framework-1 is ***NOT an activist***, although there are some variants that allow limited degrees of activism. In this view, the ASHA has to serve as the ANM's assistant. She should be accountable to the departments. There is a need for her to maintain registers, submit forms, attend meetings, and be available at short notice. All these do not sit comfortably with the activist image. Performance based payments are seen as desirable, because it would limit her only to incentivised tasks, and would reduce the chances of pressures of the ASHA seeking regular employment. However fixed payments are welcomed by some of those in this framework, as leading to better control over the ASHA. Those with such an understanding would argue that the drug kit would not be needed except for disbursing oral pills, condoms, and IFA. Her contribution to saving lives is only to the extent that pregnant women attend the VHND, and access institutional delivery or children get immunised or sick children are referred to see a doctor.

The second framework is that of the modified Community Health Worker (***Programme Theory 2 or Framework of Understanding-2***); akin to the Mitanin model. Here again, the link worker role is seen as important but curative care skills are also seen as an essential and necessary supplement to the link worker. A more substantial drug kit with life saving drugs such as ORS, cotrimoxazole and chloroquine, is essential to serve this role. On the job mentoring and support is needed for effective skill building and retention. Those with this understanding believe that a large benefit is accrued because the ASHA is equipped to provide direct interventions at the community level which save lives. This includes giving ORS for diarrhoea, providing essential newborn care, and giving cotrimoxazole for ARI, or anti-malarials for fever in an endemic area. Increasing institutional delivery would help reduce newborn mortality, but it would be a long time before facility based care reaches that level of efficiency and anyway after 48 hours it is at the home that care has to be provided. Further those who have this understanding reason that the ASHA's ability to respond to immediate "felt" health care needs lend her credibility and this helps her to reach out to the marginalised who are not accessing government services such as immunisation and institutional delivery, and thus make her role as a facilitator more effective.

One variant of this is the traditional NGO led CHW model[7], where a higher set of curative skills defines her central role and constitute a better form of access to primary health care, to be supplemented by the Public health system. The facilitator role is not opposed but played down. This model is not in operation in the ASHA programme, but votaries of this position could interpret the current ASHA programme differently. Those holding this programme theory would be more concerned that if the ASHA were only a link worker in a context where the public health system is ineffective, she could become a broker and

7 Abhay T Bang, Rani A Bang, Sanjay B Baitule, M Hanimi Reddy, Mahesh D Deshmukh; Effect of home-based neonatal care and management of sepsison neonatal mortality: field trial in rural India; The Lancet Vol. 354 - 1999.

amenable to being bought off by the private sector. But this private sector linkage could be seen as a good alternative by some others. In Programme Theory 2, the ASHA programme leads to outcomes because ability to provide services saves enormous lives and makes her even more effective as a link worker. It gives her an independent standing and bonding with the community to be able to play some degree of mobilisational roles in addition.

Those who see the ASHA primarily as an "***activist***", with a major social mobilisation role can be categorised as belonging to the ***Programme Theory 3 or Framework of Understanding-3.*** ASHA achieves health outcomes by reaching out to poor and marginalised communities and enables them to secure their entitlements. Those who see the programme through this framework take the view that service provision could distract the ASHA and set them on a path to seeking full time employment, or let the state/paid workers off their responsibilities. On the other hand, they are also concerned that mere facilitation of a few focussed services would make them subservient and unable to articulate rights. Payments are not desirable for this reason. The ASHA programme works because it pressurises the health system to work. Some descriptions of the Mitanin[8] programme highlight this activist aspect of the Mitanin.

Categorising stakeholder perceptions into these three categories better informs interpretation of the findings. It helps bring the subjective dimension into the equation of inputs and outputs. It helps us to understand why certain aspects of the national guidelines are adhered to and why certain parts get ignored. It also enables an improved understanding of why the well defined plans and strategies, encounter multiple implementation hurdles. This understanding also enables us to anticipate how the findings and recommendations of this evaluation, would be viewed by different stakeholders. Finally, it would also help stakeholders appreciate perceptions that are different from theirs and re-examine their own.

The ASHA guidelines itself, especially the roles and responsibilities that are defined and based on it the mechanisms proposed for implementing the programme, are consistent with the second framework of understanding. However during implementation, key mechanisms like the process of selection, the emphasis given to social mobilisation, the seriousness given to refilling the drug kit, the development of a strong support and training system are all modified based on the perceptions and understanding of the implementer.

Civil society intervened effectively with key decision makers nationally at the time of creation of NRHM and persuaded the shaping of national guidelines in which the ASHA is primarily a person who is both activist and community level care provider. Public health literature[9] demonstrates that an ASHA can have a health impact through community level care provision for common causes of childhood mortality. However both civil society and public health experts have failed to convince the implementing officials, both medical and general administration, of how a community health worker is effective in improving health status.

8 Thiagarajan Sundararaman; Community health-workers: scaling up programmes;The LancetVOl 369- 2007.

9 Andy Haines, David Sanders, Uta Lehmann, Alexander K Rowe, Joy E Lawn, Steve Jan, Damian G Walker, Zulfi qar Bhutta;Lancet- Achieving child survival goals: potential contribution of community health workers, 2007.

However both civil society and public health experts have failed to convince the implementing officials, both medical and general administration, of how a community health worker is effective in improving health status.

A large section of those implementing the programme see the ASHA's effectiveness as emanating only from her bringing patients to the facility and to the VHND and would largely for reasons of professional predilections or administrative concerns about control and management, prefer to limit her to this role. The role in both changing health behaviours and in prompt response to common but potentially life threatening illness is ill understood and down-played. State implementation officials are willing to concede that some level of mobilisation tasks is needed for her to be effective. District medical officers are willing to concede that some degree of service provision role is needed for her credibility. However these factors are really quite peripheral in this perspective.

At the level of ANMs and ASHAs however, the understanding of ASHA roles is consistent with the official national guidelines, and the mix of roles envisaged for the ASHA, but there is a limitation on how much their "agency" alone can achieve if the implementation mechanisms above them have such a restrictive perception. Orissa, we note is a clear exception to this pattern- for in this state all levels of the programme implementation chain share the framework of understanding – 2 and have a more informed public health understanding of how ASHAs work impacts on infant and maternal mortality.

Orissa is the single state where the ASHA is perceived by stakeholders at all levels, to span all roles, i.e., mobiliser, facilitator, and service provider. To a certain extent, this is also the case in West Bengal, where although the predominant understanding is that of a Link Worker, there is also acceptance of the service provider role. In Assam, we see that there is a divergence of programme understanding, with state officials subscribing to the link worker role, and the staff at district and block level, viewing her in the CHW framework. At the district level in Assam, officials also perceived that the ASHA also appears to be functioning in an activist role, breaking down behavioural barriers to services, and facilitating women's access to entitlements. In Rajasthan, Bihar, and Kerala, the Link worker understanding dominates the landscape. There is little room to view her as a social activist, and much less as a provider of community level care. In Andhra Pradesh and Jharkhand in the initial phase the programme was initiated with the framework of understanding that the ASHA is an activist, While the ASHA training in Andhra Pradesh was conducted in keeping with Programme Theory 3, the subsequent support for the programme was influenced by the link worker perspective. In Jharkhand, NGOs were involved in selection and training of the ASHA in the early phase and brought an activist perspective, but after their role was reduced the link worker understanding, became more dominant.

Across the board, however, there is grossly insufficient understanding of why children die- and how lakhs of diarrhoeal deaths and deaths from ARI and fevers and newborn deaths could be averted by the simple actions that an ASHA can be easily trained to undertake. Also there may be an overestimation of lives saved by immunisation and the possibilities and potential of facility based care in highly deprived contexts. There are other national programmes as in Brazil, where community care for illness by the community health worker is limited, but there is a medical doctor and a nurse made available full time for every unit of population of 4000 who is supposed to make the home visit

to the sick child, once a CHW picks it up. We are currently hard-pressed to provide referral care to a sick child in even one site per district. This is despite the clear recommendation in the XI Five Year Plan and stressed by the Task Force on ASHA on the importance of provision of community level care for the newborn and sick child.

Whatever the reasons, the huge investment in time and effort in the ASHA programme, is substantially undermined if programme implementers are not convinced of key dimensions of the conceptual framework. This chapter has discussed many of the lacunae in management, payments, support structures, training etc. This concluding discussion on perceptions helps us understand and discuss the why of this.

A statewise discussion of the perspectives and understanding, or Programme Theories is provided in Section 1g of Part 2 of this report. In Chapter 7, we also correlate the programme theories with the way mechanisms were constructed in the various states and outcomes were realised.

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CHAPTER 3

Profile of the ASHA

In this section we present the finding of the study with regard to age, marital and family status, educational qualifications, family income and poverty levels, community profile, occupational background of the ASHA and the population and households allotted to her. We also describe here what ASHAs state as their reasons for becoming ASHAs.

I. Individual Characteristics

Age structure: The study shows that without exception in all states, the ASHAs were women. It also showed that in all states except Kerala, about 60% of them were in the 24 to 35 age group. In Rajasthan and Jharkhand the remaining were mainly in the 20 to 24 age group, whereas in Kerala, Assam, Orissa, Bihar and West Bengal the majority of the remainder were above 36 years of age.

Marital and Family Status: In terms of marital status, only 5% of ASHAs in Bundi, 8% in East Godavari and 12% in West Singhbhum were unmarried. In every state anywhere from 87 to 96% of ASHAs were currently married and the rest (up to 10%) were married women who had since been widowed, divorced or separated. Karimganj in Assam and Nayagarh in Orissa had 12% and 13% of ASHAs respectively in this last category. The majority of the married ASHA had two or fewer children. In all states about 25% of ASHAs (except 76% ASHAs in Bihar) had over two children. The next was Assam with 42% having more than two children, but this perhaps relates to the higher average age of ASHAs, as 36% of ASHAs were over 36 years of age.

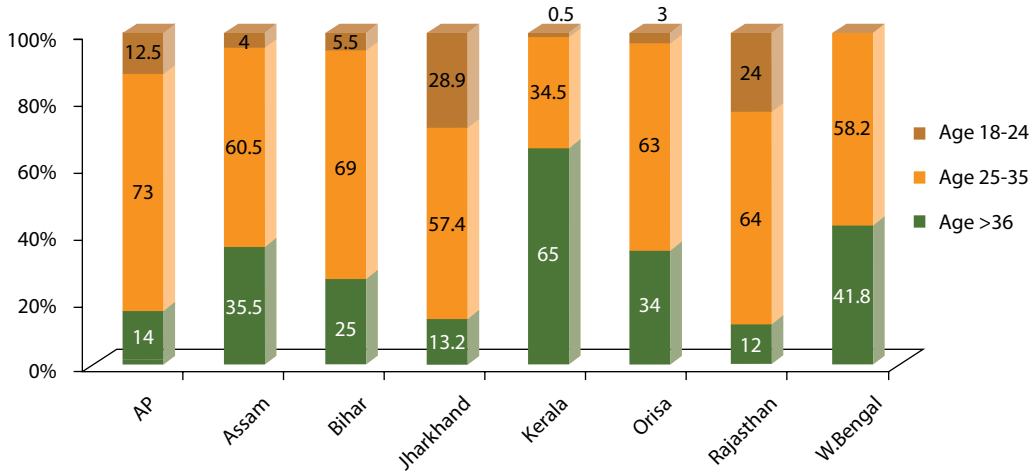

Figure 1: Age distribution of ASHAs

II. Educational Qualification

Four of eight states have relaxed the Class VIII minimal educational qualification and they are both states with high tribal populations and low literacy. 27% of ASHAs in Jharkhand, 37% of ASHAs in Orissa, 25% in Andhra Pradesh and 11% in Bihar are primary school pass. Looking closer, even in these states the relaxation has been mainly due to the need for relation in the predominantly tribal districts of Nayagarh in Orissa (49%), Dhanbad (35%) & West Singhbhum (19%) in Jharkhand, Khagaria (22%) in Bihar and Khammam district (30%) in Andhra Pradesh. The only non tribal district where relaxation was encountered was East Godavari (20%) of Andhra Pradesh state. Perhaps this was also due to the selection being done in Andhra Pradesh before the ASHA guidelines were in place and the 8th class norm mooted. The frankly illiterate is an insignificant level.

Curiously in every state except for Rajasthan over 50% of the ASHAs were also high school pass, which would make them eligible for nursing school entry later. Even in Rajasthan about 23% of the 72% who were middle school pass had passed high school.

Inter–district variation within a state is often wider than inter state variation. Interesting to note are district level variations within states in the proportion of ASHA at middle school level. (Table 10) In Bihar 29% of ASHA are at this

Table 10: Educational status

	Never been to school	Primary school	Middle school	Secondary school	Graduates	Post graduates	NA
Kerala	**0**	**0**	**8.5**	**81**	**10.5**	**0**	**0**
Trivandrum	0	0	7	75	18	0	0
Wayanad	0	0	10	87	3	0	0
Orissa	**0**	**37**	**0.5**	**60.5**	**1**	**0.5**	**0.5**
Nayagarh	0	49	1	49	0	0	1
Angul	0	25	0	72	2	1	0
W. Bengal	**0**	**0**	**13**	**80.4**	**5.4**	**0.5**	**0.5**
Malda	0	0	14.4	78.4	5.2	1	1
Birbhum	0	0	11.5	82.8	5.7	0	0
Assam	**1**	**0.5**	**49.5**	**46.5**	**1.5**	**1**	**0**
Dibrugarh	2	0	29	66	3	0	0
Karimganj	0	1	70	27	0	2	0
Rajasthan	**0.5**	**1.5**	**71.5**	**22.5**	**2.5**	**0.5**	**1**
Banswara	0	1	74	23	1	0	1
Bundi	1	2	69	22	4	1	1
AP	**3**	**25**	**3.5**	**65**	**1**	**0**	**2.5**
East Godavari	0	20	2	75	2	0	1
Khammam	6	30	5	55	0	0	4
Bihar	**0.5**	**11**	**29**	**57.5**	**1**	**1**	**0**
Khagaria	0	22	8	70	0	0	0
Purnia	1	0	50	45	2	2	0
Jharkhand	**0.5**	**26.9**	**8.1**	**60.4**	**3.6**	**0**	**0.5**
Dhanbad	0	35	5	56	3	0	1
W Singhbhum	1	18.6	11.3	64.9	4.1	0	0

level, with 50% in Purnia and 8% in Khagaria, and in Assam 50% of ASHA (with 29% in Dibrugarh and 70% in Karimganj). Similar variations are also seen at secondary school level in Bihar (58%) with 70% in Khagaria and 45% in Purnia; in Orissa (61%) with 49% in Nayagarh and 72% in Angul and in Andhra Pradesh (65%) with Khammam 55% and EG 75%) and in Kerala 81% (Wayanad 87% and Trivandrum 75%).

About one to five percent of ASHAs are either graduates or post graduates, except in Kerala where 10.5% of ASHAs were graduates. (18% from Trivandrum).

III. The Economic Status of the ASHA

Defining socio-economic status is at the best of times a difficult proposition. We went by what families report as their average monthly family income, asset ownership of families, and formal BPL categorisation by the state as reported by ASHAs. In addition we looked at who was the main earning member of the family and what the ASHA reported as her main source of income. Finally we also looked at caste and minority religion patterns.

Family income: Most ASHAs across states and districts report a monthly family income in the range of Rs. 1000 to Rs. 3000. Here clearly intra-district variation is very low as compared to the intra-state variation. About 58 to 78% of the ASHAs in Rajasthan, West Bengal, Bihar and Andhra Pradesh reported a family income between Rs. 1000–3000 per month.

Table 11: Family income per month

	< 1000	1000-3000	3000-5000	>5000	NA
Kerala	**65**	**27**	**5.5**	**2.5**	**0**
Trivandrum	65	25	8	2	0
Wayanad	65	29	3	3	0
Orissa	**35**	**40**	**16**	**8.5**	**0**
Nayagarh	44	43	9	4	0
Angul	26	37	23	13	0
W. Bengal	**7.1**	**57.1**	**15.2**	**20.7**	**0**
Malda	11.3	54.6	15.5	18.6	0
Birbhum	2.3	59.8	14.9	23	0
Assam	**7**	**42**	**37.5**	**13.5**	**0**
Dibrugarh	3	37	46	14	0
Karimganj	11	47	29	13	0
Rajasthan	**11.5**	**66**	**11**	**11**	**0.5**
Banswara	12	69	11	8	0
Bundi	11	63	11	14	1
AP	**13**	**77.5**	**5**	**2.5**	**2**
East Godavari	16	75	3	3	3
Khammam	10	80	7	2	1
Bihar	**7**	**65**	**21.5**	**4.5**	**2**
Khagaria	12	66	19	2	1
Purnia	2	64	24	7	3
Jharkhand	**22.3**	**65**	**8.1**	**4.6**	**0**
Dhanbad	13	73	7	7	0
West Singhbhum	32	56.7	9.3	2.1	0

If the median is in the Rs. 1000–3000 monthly income group, at the lower end of the spectrum, ASHAs in Kerala, Orissa and Jharkhand are the poorest with 65%, 35% and 22% earning less than Rs. 1000 per month. This could be expected in Orissa, and Jharkhand both of which have very high poverty levels, but Kerala is a surprise here. Is it a perception of poverty, or is Kerala really selecting ASHAs from the poorest of the poor?

On the other hand in Assam, 38% of ASHAs report a family income of more than Rs. 3000 per month and 13.5% report an income of over Rs. 5000 per month. Next is Bihar where 22% report a family income of Rs. 3000 to Rs. 5000 followed by West Bengal with 15% in the Rs. 3000–5000 per month range and 20.7% over Rs. 5000. In Orissa 16% reported a monthly family income of Rs. 3000–5000 and 8.5% over Rs. 5000 per month, with most of the higher incomes being reported from the more developed Angul district.

The pattern seen in asset ownership, i.e. owning more than two acres of land-the tribal districts of West Singhbhum (60.8%) and Banswara (64%) lead with Birbhum, Bundi, Dibrugarh. Angul, Purnia and Khammam following. The agriculturally fertile areas of Kerala and East Godavari, which had large villages show least ownership. Other assets-house with over three rooms, house with brick walls, television, motorised vehicle etc were not helpful but confirmed that most ASHAs were from poor families. Thus about 5% of ASHA come from families too poor to have any one of these assets, and in Banswara this could be as high as 18%. On the other end some 10% would be having a motorised vehicle in most states-with 29% of ASHAs in Rajasthan having a motorised vehicle. (38% in Banswara).

BPL categorisation: In terms of BPL categorisation 52 to 67% of ASHAs in Jharkhand, Kerala and Orissa belong to BPL category except in Andhra Pradesh where 95% of ASHAs belong to this category. In West Bengal only 24% of ASHAs are from BPL families and in Rajasthan, Bihar and Assam it is around 37–39%. This possibly relates to the differences in way BPL are counted in different states. In Andhra Pradesh over 70% of households are categorised as BPL and therefore over 95% of ASHAs become so categorised.

Main earning member in the family: Predictably, about 65–89% of the respondents said the husband is the main earning member and for about 5%–20%, it is the father. The ASHA herself is the main bread winner in a little over one fifth 22% in Orissa and 18% in Assam and about 10% in Bihar and Rajasthan while it was only up to 7% in other states.

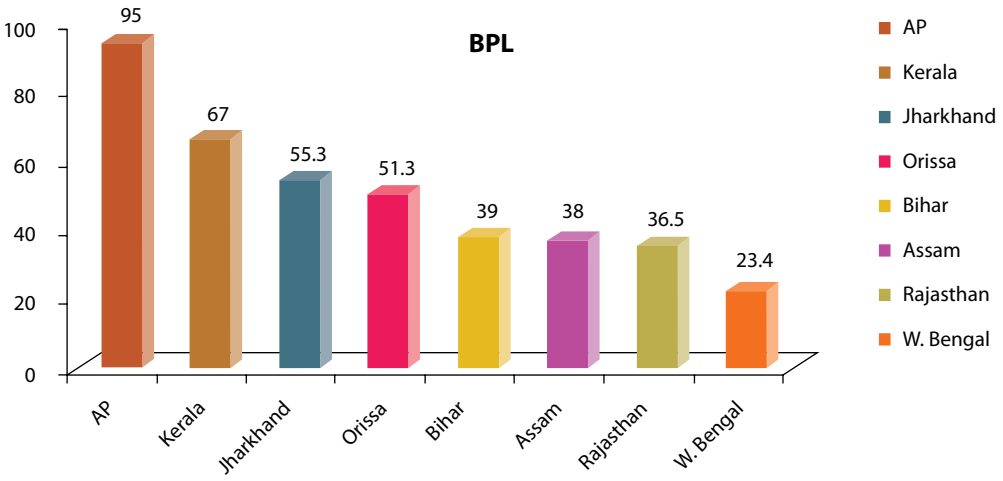

Figure 2: BPL categorisation of ASHAs

Main income generating activity of ASHAs: One of the key concerns and a recurring issue for debate is whether voluntarism among the ASHAs is possible, whether the programme is displacing her from livelihood and to

what extent is the programme demanding services from a woman in need of a livelihood. The data show that in terms of the ASHAs description of their own main income source, West Bengal (91%) and Rajasthan (80%) have most ASHAs reporting ASHA work as being the main individual income source (distinct from family income). This correlates with the policy in both states of providing a fixed monthly income. Andhra Pradesh with a fixed payment policy in tribal districts has only 51% of ASHAs in East Godavari district reporting the ASHA work as their main source of income. 83% of ASHAs from Bihar also reported ASHA work as their main source of income followed by 75% of ASHA in Assam's Karimganj district, and 57% in Kerala. Orissa has 19% of ASHAs reporting this work as their main source of income.

Where ASHA work is not the main source of income, it is either daily wage labour or agriculture on her own land; the peasant household which provides their main income. Curiously about 9% of ASHA interviewed in Nayagarh district in Orissa report salaried employment (public or private), as the main income source.

IV. The Social and Community Identity of the ASHA

SC/ST status: One of the concerns of the ASHA programme has been whether it has provided adequate representation to the weaker sections and marginalised communities to become ASHAs.

We looked at the percentage of ASHAs who were SC or ST status in our sample and then compared it with the percentage of SC and ST in the district population by 2001 census. The pattern that emerges is that as a rule, the selection has been considerably equitous with a number of districts showing positive affirmative action to get a greater percentage of ASHAs from this category. Even where the selection is less than expected from the population percentage, we find that it is not much less. However from the viewpoint that in these districts being just about equal to district proportion is not good enough Trivandrum, Wayanad, Dhanbad, Angul, Bundi, Purnia, Birbhum, Malda and Khagaria districts have lagged behind.

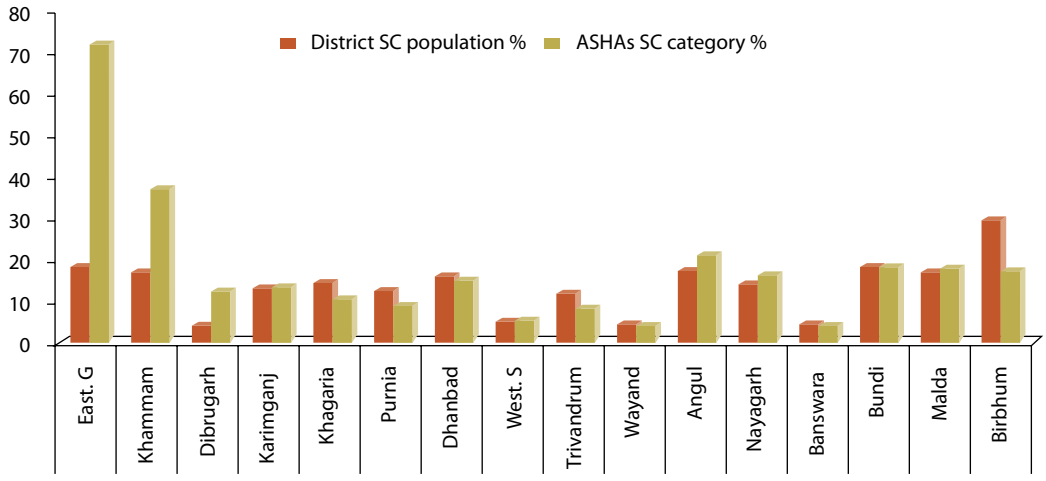

Figure 3: SC representation of ASHAs

Religion: Minority representation amongst ASHAs as compared to minority presence in the population is also good except in Karimganj, Assam, Bihar,

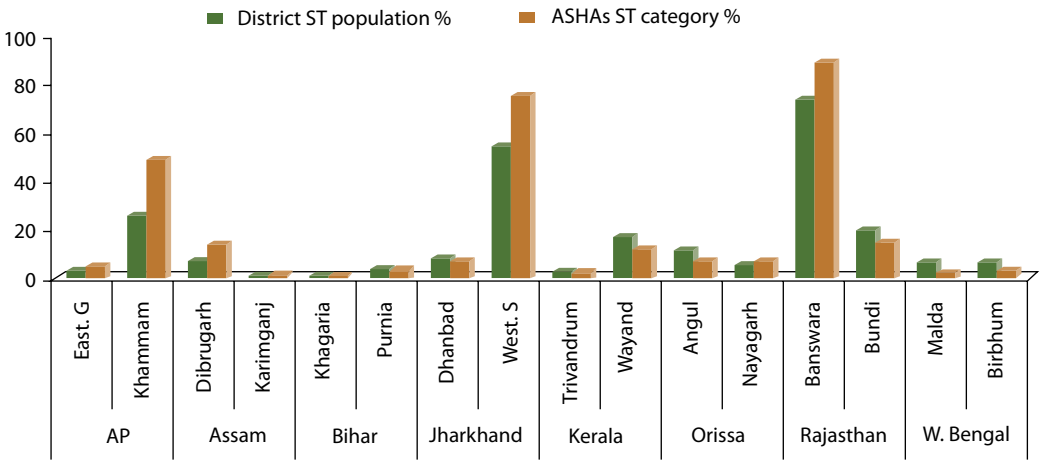

Figure 4: ST representation of ASHAs

Jharkhand and Rajasthan. We note that in West Singhbhum district most of the tribal respondents chose to call themselves as neither Hindu nor Muslim or Christian whereas the census categorises them as Christians or Hindus, and does not provide for a distinct tribal religious identity.

V. Access to ASHAs

Population Coverage: The central guidelines for ASHA selection and population coverage stipulate that one ASHA to be selected per 1000 population. The three criteria for population coverage applied by states broadly included: (i) one ASHA per Anganwadi Centre, (AWC) (ii) one ASHA per 1000 population and (iii) one ASHA per hamlet or habitation. States have made the decision to reduce the population coverage in areas such as geographically remote areas or tribal hamlets, to ensure that the ASHA is able to reach the most geographically and socially marginalised groups.

In Assam although the state initially followed the one per 1000 norm, programme guidelines were subsequently modified to enable one ASHA being selected per hamlet in the tribal areas to ensure adequate coverage. In Orissa, one ASHA per Anganwadi was selected but recently the state has made a decision to select one ASHA per 300 population in KBK (marginalised) districts. In Rajasthan, the ASHA Sahayogini (or helper) of the AWC was appointed as the ASHA, and therefore the population coverage was identical to that of an Anganwadi centre, which is roughly hamlet based. In Andhra, the norm of one ASHA (or WHV) per 1000 population had been established pre NRHM. In Kerala and West Bengal one ASHA per 1000 population was chosen. The method of determination in West Bengal follows a strict arithmetical calculation at the higher levels. The number of ASHA positions for each block is "sanctioned" by the state based on estimated birth rates of blocks (based on 2001 census).

In Bihar two criteria were specified initially: that every ASHA will be selected where there is an Anganwadi, and one for every 1000 population. In the early phase of the selection, only the Anganwadi norm was considered. Since Bihar has many villages where there are no AWC, no ASHA were selected in several villages. Later the selection process was modified to follow the "one ASHA per 1000 population" norm.

In Jharkhand which followed a two phase selection process (pre NRHM and post NRHM), the Sahiyya selection in Phase I was hamlet based whereas during Phase II Sahiyyas were selected at the 1000 population norm. Only if the hamlet was too far off, a separate Sahiyya was selected for it. Given that

14 of 24 districts in Jharkhand are designated scheduled areas, this norm has resulted in large gaps in coverage.

Thus it is clear that states made modifications based not only on their specific contexts, but also learnt from the programme as implementation progressed. The pace of learning appears to depend on the management of the programme and the intensity and depth of monitoring. Although the ASHA programme was launched at the national level in 2005, the guidelines stipulated that the states should select at least one third of ASHA within the first fiscal year. State progress on ASHA selection has been slow. Except in Jharkhand and Andhra Pradesh, and to some extent in Rajasthan, few states were able to select the required number of ASHA until the first two to three years of the programme. Assam and Orissa had selected most of their ASHA by the middle of 2007. West Bengal and Kerala had selected the ASHA in the selected districts by 2008. The progress was much slower in Bihar.

Number of households and population per ASHA: It turns out that as a rule approximately 36% to 64% of ASHAs serve 500 to 1000 population in all districts. In terms of proportion of ASHAs serving over 1000 population, West Bengal has 60% of ASHAs serving over 1000 population and then follows Orissa and Rajasthan (44%), Kerala 42%; Assam 38%; Bihar 34% Jharkhand 28% and Andhra Pradesh 26%.

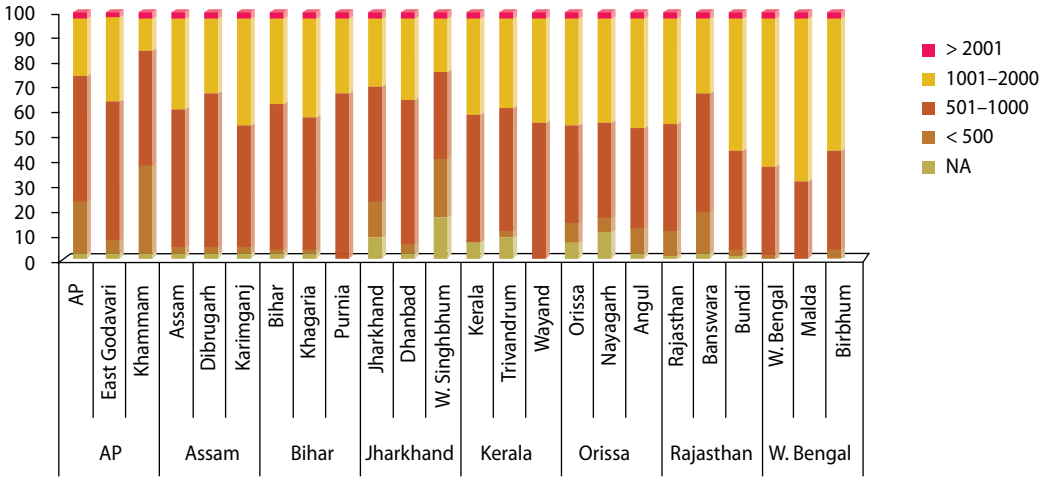

Figure 5: Population covered by ASHAs

In order of the states that have the highest number of ASHAs covering up to 100 households it is Jharkhand (24%), Andhra Pradesh (19%), Rajasthan (18%), Orissa (13%), Bihar (8%), Assam (4%) and West Bengal (2%). Some of the tribal districts such as Khammam, West Singhbhum and Banswara show this pattern whereas other tribal districts like Nayagarh do not show this pattern.

The underlying logic of population allotted per ASHA seems to be a trade off between different considerations:

- Keeping to a fixed number of ASHAs decided at district level or allocated to districts by the state, even though population densities are high. This could in some states mean that many families/hamlets are getting left out- as no ASHA is allotted to them.
- Keeping the numbers flexible to achieve an ASHA resident in every hamlet, which means more ASHAs where villages are more dispersed – Assam and Jharkhand seem to have made use of this flexibility most.

Geographic Scatter and Access: Another measure of access is related to dispersion and the ASHAs were questioned on the number of hamlets served, the distance of the furthest hamlets, use and mode of transport to reach these hamlets. Most villages were single hamlet villages with travel times of less than 30 minutes to reach any house and walking was the most common mode of transport. However over 20% of ASHAs reported having to travel over one hour in the both districts of Andhra Pradesh, in Karimganj in Assam and Banswara in Rajasthan.

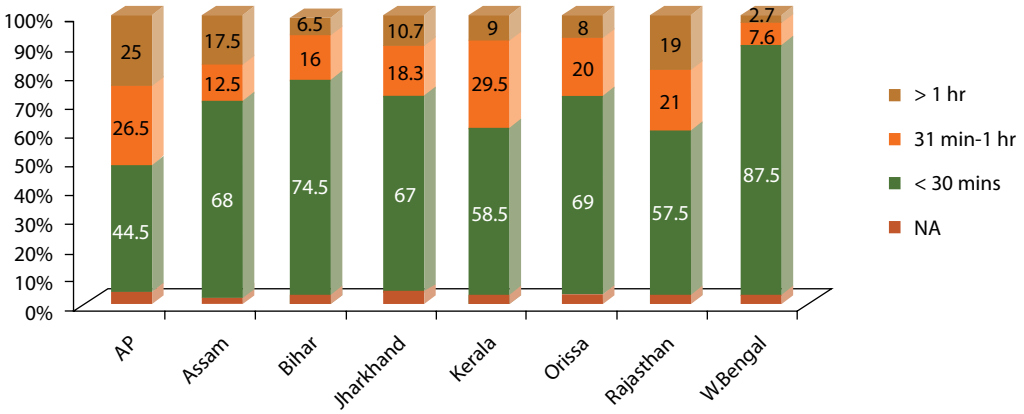

Figure 6: Time taken by ASHAs to reach the most distant hamlet in their coverage area

Mode of transport did not seem related to distances – both districts of Orissa reported 71% and 88% use of bicycle, 79% of Dibrugarh, and 18% of Birbhum and 19.6% of W. Singhbhum used bicycles. In the first three of these situations government policy to sanction a bicycle to the ASHA may have made the difference.

The number of ASHAs who have to cover only one hamlet is 34% or less in all districts except in Andhra, where it is about 62% and Kerala where it is about 65.5%. In Assam, Rajasthan, Jharkhand and West Bengal about 36%–45% of ASHA cover two to three hamlets while this percentage was less than 30% for remaining four states. ASHAs covering four or more hamlets were highest in Rajasthan and West Bengal, almost 27%. In Wayanad about 10% of ASHAs required an auto or tempo to reach their hamlets but for the most part others reported walking or cycling to reach their hamlets.

Most ASHAs in 11 districts (60–70%) state that they were the only ASHA in their village with the highest percentage from Assam, about 90%. In West Bengal's Birbhum district, Andhra Pradesh's East Godavari district, Bihar's Khagaria district and in Kerala about 56.3%, 67%, 70% and 77%, ASHA respectively said that there were other ASHAs in their village, pointing to these villages having more than 2000 population.

VI. Marginalisation and Access

Significant numbers of ASHAs reported the existence of poor and marginalised sections in their coverage area, indicating reach to this section. About 97% of respondents in Orissa said that there are poor and marginalised sections in their coverage area. In Andhra Pradesh, Kerala and Assam 85–90% said the same. In West Bengal and Bihar about 72% of respondents said that there are marginalised communities in their coverage area. However, 58% of ASHAs in Dhanbad district of Jharkhand and 62% in Banswara district of Rajasthan said that there are no marginalised or poor sections in their coverage area. Of those who stated that there were marginalised sections in that area, a

significant percentage also said that it was difficult to access these marginalised households-whether due to distance or due to social barriers was not clear.

About 60% of ASHAs who reported marginalised households in Assam's Dibrugarh district, 38% ASHA in Wayanad and 36% in West Singhbhum, followed by East Godavari, Nayagarh, Angul, Bundi and Malda with 25–30%, Banswara, Khagaria and Purnia with 15–20% and up to 10% in the remaining districts perceived the existence of such barriers making access to these marginalised sections difficult.

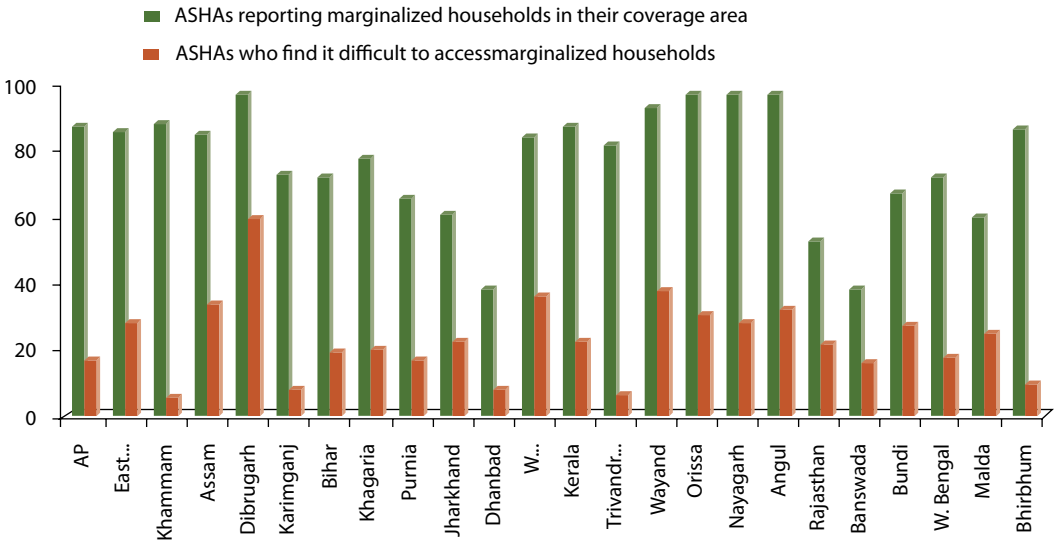

Figure 7: ASHAs reporting marginalised house holds and difficulty to access such households

It is not immediately clear whether the reason for the social barriers was because the marginalised sections are reluctant to use their services, or that ASHAs find it difficult to go these houses or whether the ASHA herself is from a marginalised community and her acceptance in other sections was limited. We explored this question further by looking for a statistical relationship between the caste of the ASHA herself and her perception of marginalisation and difficulty in access to these households? ASHAs from the SC/ST community in East Godavari ($p = 0.0016$), in both districts of Assam (p value of 0.006 in both districts), in Trivandrum district of Kerala (p of 0.049) had a significantly higher perception of marginalisation and difficulty in access than other ASHAs. In Malda the association was with ASHAs of an OBC background ($p = 0.05$). In other districts it was both equally-non SC/ST ASHAs finding it difficult to access the marginalised sections and ASHAs from marginalised sections finding it difficult to access the whole population.

In order to address the issue of social exclusion, frequent household visits to the marginalised households was reported as the most common step taken by ASHAs except for Bihar where steps taken to facilitate use of AWC and SHC services was the most common activity. A high percentage of 68% ASHAs from Kerala reported making more frequent household visits followed by 43% from Assam and 26% from Andhra Pradesh. For the remaining states the same was reported by less than 15% of the ASHAs. Similar trend can be observed for organising health camps in these areas and steps for enrolling for AWC and SHC services across all states but with much lower frequencies. Overall ASHAs from Kerala are most active in taking measures for reaching out to the marginalised sections followed by Assam and Andhra Pradesh.

In a later chapter we measure the coverage or outreach of the ASHA to her potential service users, and this gives us an accurate objective measure of the extent of exclusion. The graph in Figure 7 shows how recognition of marginalisation and reported affirmative action to address marginalisation correlates with objective evidence of exclusion. A possible interpretation of this pattern is that marginalisation is present in all states, but where it is recognised and acted upon, the outreach is better. Where its existence is more often denied, the exclusion is more.

VII. Subjective Profile of the ASHA

Every ASHA surveyed was asked why she chose to become an ASHA and offered a set of nine answers from which she had to choose and rank the top three in order of importance. The eight choices were 1. Serving the community 2. Hope for a government job 3. Financial reasons 4. Social recognition 5. To take care of own children, 6. Opportunity to be independent, 7. Lack of health services in the hamlet 8. Opportunity to seek knowledge.

These were based on earlier qualitative work that looked at why ASHAs choose to become ASHAs. It could be safely assumed that if a choice was not within the first three ranks it was not a significant factor that influenced her decision.

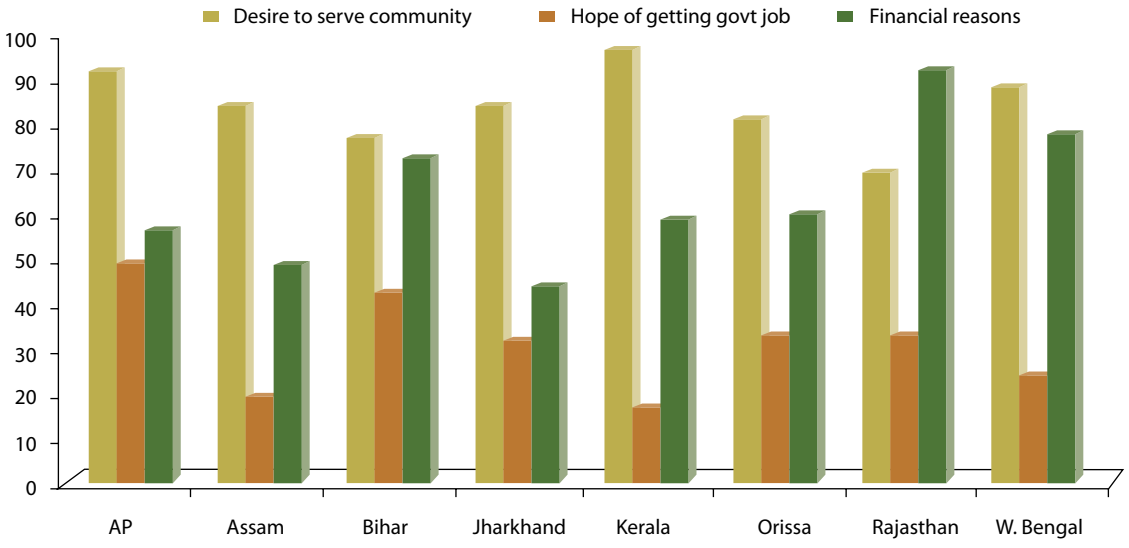

Figure 8: Reasons for becoming an ASHA (first three choices added together)

Clearly the desire to serve the community emerged as the foremost reason for becoming an ASHA-well above all the other factors. As first rank choice, ASHAs from Andhra Pradesh stated it at 85%, Assam at 80%, Kerala, 78%, Jharkhand 73% and Orissa at 63%. This is a relatively weaker factor in Bihar (57%), Rajasthan (43%) and in West Bengal at (54%). Birbhum district recorded it as low as 39% while Khagaria recorded 41%. But even in these last four districts if we take the second and third choice into consideration then it invariably crosses 80%.

The second most important factor stated is financial. Only a small proportion quoted it as the most important factor, about 28% in West Bengal of which about 41% were in Birbhum district, 22% in Rajasthan and 19% in Bihar while it was 10% or less in other districts. However if we consider whether it figured

within their first three choices, it rises to about 60% in West Bengal and Bihar and about 50% in the other states and Jharkhand showing about 29% This is still lower than what one would expect.

Hope of getting a proper government job was cited as a reason by only 3% to 6% of respondents in most states except for Rajasthan where Banswara had 15% of ASHAs with such an aspiration and Khagaria in Bihar where 14% aspired for a government job. Again if we add in second and third choice into the calculation it could rise from anywhere from 15 to 30% except for Andhra Pradesh with 40% at second rank.

The other reasons all ranged from 1 to 15%, even if we were to combine all other choices. Of the other choices-recognition in the community (highest 25% in Kerala) and lack of health services in the community and even opportunity to seek knowledge and take care of one's own children better could be seen in the group of altruistic factors – whereas the opportunity to become independent is at least partly related to the desire for financial independence.

VIII. Selection of the ASHA

The national guidelines were explicit on the process of selection. The selction was expected to be facilitated by village level meetings, shortlisting a number of candidates, from which the Gram Sabha would select the final names. The Gram Panchayat would endorse the selection and forward the name to the health authorities. The process was to be supported through the appointment of facilitator who would be trained to mobilise and enable the articulation of the voices of weaker sections. Financial support for social mobilisation to enthuse and inform community participation was also provided.

These national guidelines were modified at various levels. First by the states, then by differing interpretations and perceptions of district authorities and

These national guidelines were modified at various levels. First by the states, then by differing interpretations and perceptions of district authorities and finally by the power of the local stakeholder(s). Constructing a picture of how selection finally took place is a challenge- not the least because as we realised, different formal rules may co-exist with informal practice.

Criteria for ASHA selection (in National Guidelines)

The general norm will be "One ASHA per 1000 population

Criteria for Selection

- ASHA must be primarily a resident of the village; Married/Widowed/ Divorced, and preferably in the age range of 25 to 45 years.
- ASHA should have effective communication skills, leadership qualities, and be able to reach out to the community.
- She should be a literate woman, with formal education upto eight class.
- This may be relaxed only if no suitable person with this qualification is available
- Adequate representation from disadvantaged population groups should be ensure to serve such groups better.

Source: Accredited Social Health Activist (ASHA) Guidelines, National Rural Health Mission, Ministry of Health and Family Welfare, Government of India, (2005).

finally by the power of the local stakeholder (s). Constructing a picture of how selection finally took place is a challenge- not the least because as we realised, different formal rules may co-exist with informal practice. Thus even with a formal statutory committee, one or other member could have his or her say, and the others on the committee would perceive or exercise little influence or ownership. The perception of how selection occurred could vary between different respondents. In Section II of Part 2 of the report, we present a set of comparative case studies in each states, where we have combined qualitative information of the first phase with responses to structured questionnaires administered to ANMs, AWWs, PRIs and ASHAs to construct the selection process.

We find that each of the eight states studied used a significantly different process for selection, though most are not conscious of their having modified the national guidelines so comprehensively.

There are several narratives of how selections were made and the role played by each of the key stakeholders at the field level- the ANM, the AWW, the PRI member and Pradhan and the local NGO- as well as supervisory medical officers. One conclusion is that no matter what the formal process laid down, it is either the ANM or the Panchayat member who took the lead and influenced the final decision- more often the former. However to the extent that they understood the purpose and process of the programme, different forms of consultation with the community were undertaken, and these have led to a fairly good selection across the states. We define "good" as conformity with the guidelines for ASHA eligibility, in terms of caste and community representation, in terms of stakeholder (ANM, AWW, PRI) acceptance, and in terms of functionality.

Selection by ANM, or Panchayat head acting unilaterally is reported, but only by less than 10% deviation from the norms. NGO participation in this process has been negligible except to a very limited- 6% in Jharkhand. Many of the fears of poor selection, or selections compromised by considerations of caste or economic status, becoming a major impediment to the implementation of the programme are not borne out by either the qualitative studies or the structured questionnaire responses of the ANM, AWW, PRI or the ASHA herself.

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In the states of Andhra Pradesh, West Bengal, Kerala, Orissa and Dibrugarh in Assam, the process of consultation was structured by defining a committee of three to five persons who were by government order empowered to make the decision. The ANM was always a part of this committee and possibly more often than not, the ANM's choice governed the outcome, except where Panchayats were also assertive. Where this formal process was undertaken as a way to make the selection more accountable and transparent, without undermining mobilisational and consultative processes it has worked best. Of the variety of selection processes seen and described in these states we are most impressed with Orissa where all sections felt equally involved and the outcomes were good, in terms of profile and in terms of performance. Orissa's selection process involved the shortlisting of candidates by Self Help Groups (SHGs) and selection by consensus. This process was facilitated by the AWW and supervised by the ANM. Where consensus was not reached, the decision was made by voting, with each SHG member having a vote or by final arbitration by the Block medical officer after review of the application and an interview process.

Of the variety of selection processes seen and described in these states we are most impressed with Orissa where all sections felt equally involved and the outcomes were good, in terms of profile and in terms of performance.

In West Bengal, where the structure was the most rigidly formalised with an effort to make it "merit based," flexibility in criteria were least applied and the process of community consultation was most limited. SC/ST representation was low, though it was part of the rules of selection. But in its own way, West Bengal was obsessed with the selection process being demonstrably fair and transparent and leaving nothing to chance or what is considered a highly polarised community. Thus where formal processes became a substitute for consultation as in West Bengal, ownership by all sections is low. A mobilisational process without enough consultation with ANM and Panchayat could also be counter-productive. Thus we see in Jharkhand that more unstructured but highly consultative processes like in Jharkhand led to a larger number of less educated women being selected, apparently where the educated woman was either not available or not preferred. These processes however, seem to have been robust in terms of equity in ASHAs selected.

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Andhra Pradesh had a structured process but which nevertheless had a fair level of equity in selection- but the Andhra Pradesh selection was before the NRHM guidelines were in place, and the state had not emphasised the educational criteria, but had promoted SC/ST criteria.

In Rajasthan, the existing ASHA Sahayogingis had been selected with Panchayats playing a major role. No flexibility was exercised in terms of selection criteria, especially the educational qualification. The state's low female literacy has left parts of Western Rajasthan uncovered by the ASHA programme. There is a lack of clarity and agreement between the ICDS and health department in the selection process and this ambiguity permeates the programme as well. In Bihar the selection process followed was through the ANM predominantly, and in some cases with the Sarpanch in some form of community consultation.

The bottom line is that across the states, the selection seems to have yielded desirable results in terms of motivation. In every state "community service", was a leading driver of women becoming ASHAs- and even on prompting by different types of investigators, this was the most common reply. The second most common reason- was of course financial, and one could say that for one third of women this would have been an important driver, even perhaps the main reason. Given their levels of poverty, this is not surprising. A distant third reason was access to government jobs.

There is a tentative correlation we can suggest between financial reasons as a driver and the mode of selection. The less community centred and mobilisational a process of selection, and the more formalised and bureaucratic the selection process, the more likely we are to get an ASHA whose main reasons for joining were financial or the search for a job. But we note that even in the most rigidly top- down selections, the numbers of those who stated financial reasons as their first reason was still lower than those that stated community service. Though there is much to compare and learn between different processes of selection, we again reiterate that there is little in the evidence from our study that indicates problems of selection as compromising any dimension of the ASHA programme.

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CHAPTER 4

The Functionality of the ASHA

One of the most fundamental questions about the ASHA programme is "how functional is the ASHA", and a follow up question, "if she is functional, how effective is she"?

Functionality of the ASHA is defined in terms of the activities that the ASHA is carrying out or as the activities on which she spends her time. Effectiveness on the other hand is defined by whether the intended outcomes of these activities are being realised or not. In pages 11 to 13 we have illustrated with some detailed examples the difference between functionality and effectiveness.

Functionality of the ASHA depends on the policy framework, the training and support she received, her personal understanding of the programme and what she is being incentivised for. Effectiveness or Outcomes would depend on her functionality on a given task PLUS her "coverage"- (what % of the potential users of her services are actual users), her level of skills, the support/ responsiveness from the health systems and the adequacy of her interaction for that context.

This chapter discusses the functionality of the ASHA as reported by ASHA and also from the responses of service users. Section 1 of this chapter presents an analysis of ASHA's functionality on various tasks as reported by her, and Section 2 presents an analysis of ASHA's functionality as reported by the service user. This chapter also includes a section on the role of the ASHA in community mobilisation as another indicator of her functionality. Detailed web tables are available on http://nhsrcindia.org/thematic_data.php?thematic_resources_id=1

Effectiveness or outcomes and the correlation with determinants, such as coverage, functionality, knowledge and skills, and systems support, are presented in the next chapter.

Section 1: Functionality: From the Point of View of the ASHA

The main benefit of asking ASHAs to report on what they actually did, is that it provides a clear picture of what she perceives as her current role. This then enabled us to explore further her perceptions of what exactly she means when she states that she is "counselling a pregnant woman", or a "mother on feeding" or "making a newborn visit", with a set of questions.

These questions are framed in the idiom of "what did you actually provide as a service or as counselling to the last two or three users". The ASHA was asked to name the users and the investigators cross checked the names with the individuals. The base for this set of questions was thus two newborns per ASHA who were visited and supported by ASHA anytime within the last six months. This totals to about 400 newborns in Assam, 399 in Kerala, 390 in Orissa, 385 in Bihar, 382 in Rajasthan, 368 in Andhra Pradesh, 357 in Jharkhand, and 353 in WB. However even these responses, although they provide additional depth and allow more understanding of her perception of her roles, do not allow interpretation of the actual service provision, because they still continue to be based on her own report of what she did. The analysis of actual service provision is derived from the responses of the users which are captured in the second section of this chapter.

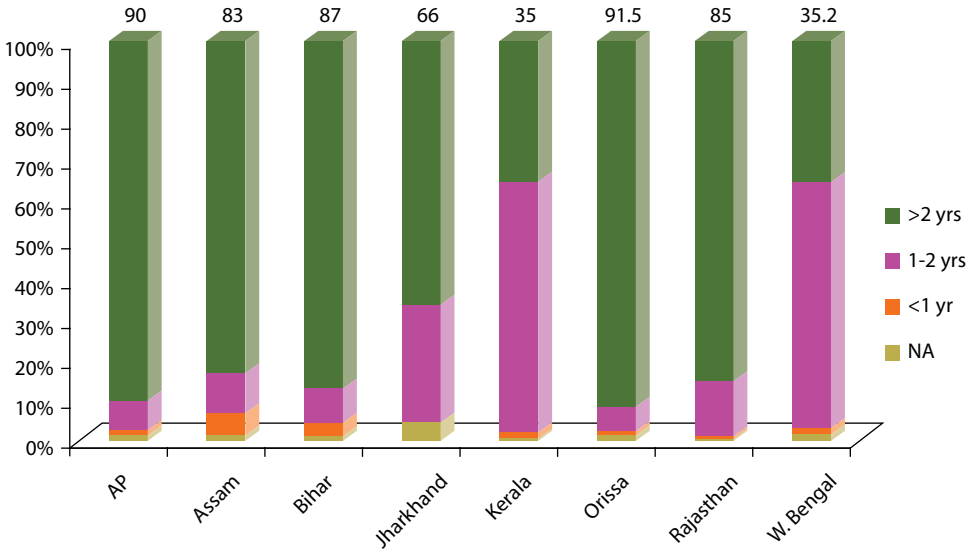

Figure 9: Duration of ASHA's work (indicating also likely drop-out rates). (West Bengal, Kerala and West Singhbhum, Jharkhand appointments were completed in 2008-09).

I. The Duration of ASHA's Appointment

Most ASHAs interviewed have been working for more than two years. Given that this interview was conducted in 2010 and the selection process was completed in 2007 there appears to be little or no dropout and change in the ASHAs. Only 5% to 15% of ASHAs in Bihar, Rajasthan, Andhra Pradesh, Assam and Orissa have less than two years of work experience. The percentage is higher in West Bengal (61%) and Kerala 63%) and West Singhbhum from Jharkhand (52%). However we note that in these districts, selection was completed only in 2009 and hence this duration does not represent a drop out.

II. Duration of ASHA's Work

The optimum hours expected by ASHA in terms of the original design was three hours per day for about five days per week. Most ASHAs across states are currently spending three to five hours in a day on ASHA related work. 78% in Andhra Pradesh (85% in EG), 83% in West Bengal, 78% in Orissa, 56% in Jharkhand, 87% in Rajasthan, 82% in Assam, 64% in Kerala and 62% in Bihar mentioned the same.

Less than 10% of ASHAs spend more than five hours on ASHA work. The percentage is higher in Assam's Karimganj district (16%) and in Kerala (33%). Across the states one to six percent also mentioned that they spend between one to three hours on ASHA work.

Another 6% of ASHAs spend less than one hour on this work. This was seen in West Bengal, Orissa, Rajasthan, Assam and Kerala also mentioned that they spend less than an hour on ASHA work. Some 15% of respondents in Andhra Pradesh, 27% in Jharkhand and 29% in Bihar said the same with 34% in Dhanbad and 40% in Khagaria districts being the highest.

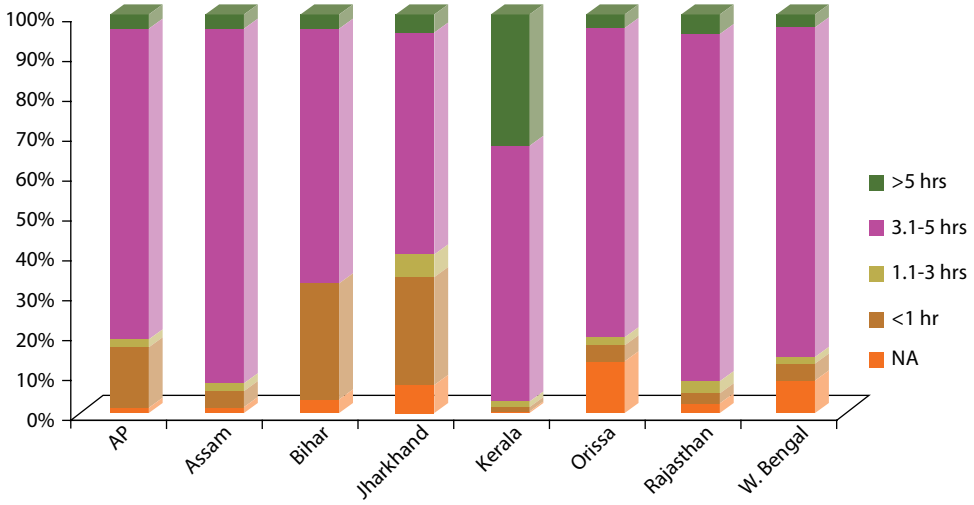

Figure 10: Average time spent daily on ASHA work.

III. The Range of Services Rendered

Before we go on to discuss what potential and actual beneficiaries state about the functionality of the ASHA in the next section, we present the range of activities undertaken as reported by the ASHA. The question is designed to enable them to recount any activity undertaken even once in a six month period. It is likely that the responses seen in Table 12, are as much of an

Table 12: Activities done in last six months – as reported by ASHA-in each state-with average-as modal value - i.e. the average of the 4th ranked and the 5th ranked state values

	Average-Mode	AP	Assam	Bihar	Jharkhand	Kerala	Orissa	Rajasthan	WB
Counselling women on all aspects of pregnancy	91.75	95	85.5	71	76.6	96.5	94	89.5	98.9
Accompanying women for delivery	90.9	93	92.5	94	89.3	57	94.5	86.5	52.2
Village meeting or any other collective meeting for health promotion	48.4	78.5	34.5	16	36	90	78	43	53.8
Visiting newborn for advice/ care	80.4	91.5	55	66	20.8	90.5	92	76	84.8
Promotion and coordination for immunisation programme	89.5	92	81	93	82.7	95.5	90.5	88.5	83.7
House hold visits	78.5	89	66.5	67	56.9	97	87.5	69.5	91.8
Nutrition counselling	62	87	25.5	39	46.7	88.5	70.5	53.5	72.8
Any malaria control related work	41.55	66.5	20.5	17	30.5	58.5	80	31.5	51.6
Consultation for minor illnesses without drug kit	41.5	43	40	9	16.8	58	66	27.5	45.1
Consultation for minor illness and use of drug kit	36.5	69	29	8.5	20.3	80	63.5	38.5	33.7
Any tuberculosis related work	44.35	58.5	11	42	20.8	72	52	18	46.7
Mobilisation for NCD camp	-	-	-	-	-	80.5	-	-	-
Supporting patients in palliative care	-	-	-	-	-	75.5	-	-	-

indicator of what was perceived by the ASHA as "her role" as it is of the skills, motivation and opportunity to provide a particular service.

In terms of work ASHAs reported as having done in last six months different states showed different patterns. We describe this below.

1. In all states two activities - counselling women on all aspects of pregnancy and promotion and coordination for immunisation programmes were consistently reported by over 85% of ASHAs, with only Jharkhand having a 77% average for both and Bihar having 71% for counselling women.
2. Surprisingly the third highest activity was visiting the newborn which was higher than 80% in all but 6 of 16 districts. Of these four two were from Jharkhand where only 20.8% reported this activity, while the other four – two from Bihar; Karimganj and Banswara were over 60%.
3. Accompanying women for delivery, the most publicly known activity of the ASHA was above 85% in all districts except Kerala and West Bengal. Even here, in Wayanad it was as high as 74% though in Trivandrum it was a low, but still a surprising 40%. Intuitively one would have not expected pregnant women in Kerala to be requiring this support.
4. Another activity reported was household visits. All but eight districts reported above 80% and another seven were in the 60 to 80% range while it was lowest in West Singhbum with 46%.
5. Nutrition counselling was reported as an activity by over 70% from all districts of Kerala, Andhra Pradesh and West Bengal, and from Nayagarh- and less than 50% in the remainder.
6. Village meetings or any collective meeting for health promotion, an indicator of the mobilisation role was varied, with six districts- Andhra Pradesh and Kerala and Orissa reporting a higher than 70% activity level, while it was less than 50% in all the rest. The lowest figures were reported from Bihar – 12% in Khagaria and 20% in Purnia.
7. In community level care for illness and use of drug kit, only Kerala, Khammam and Nayagarh showed an adequate over 70% response. In Bihar it was as low as 8.5% of ASHAs with 2% from Purnia.
8. In malaria only four districts including two from Orissa and in tuberculosis only the two districts of Kerala and Khammam showed over 60% activity level.
9. In Kerala 81% of ASHA reported mobilisation for Non Communicable Diseases (NCD) camps and 76% responded positively for supporting patients in palliative care- activities that are currently exclusive to Kerala alone.

In all states two activities - counselling women on all aspects of pregnancy and promotion and coordination for immunisation programmes were consistently reported by over 85% of ASHAs, with only Jharkhand having a 77% average for both and Bihar having 71% for counselling women.

A) Care in Pregnancy

Ante-natal care, promotion of institutional delivery and post natal care

Most ASHAs reported that they were active in carrying out these tasks. However since we had detailed information on this aspect from the large sample of service users we met we discuss this in greater detail in section 2 of

this chapter. However on certain aspects like management of complications, where it is difficult to investigate through service users responses and on issues like the help provided on JSY payments, where the ASHAs perception may be different we have reported on it in this section.

Management of complications

Approximately 35- 40% of ASHAs reported having encountered pregnant women with complications in the states of Bihar, Assam, Jharkhand and Rajasthan, Andhra Pradesh, West Bengal and 52% in Kerala, and 57% in Orissa. Of these, most of the ASHAs were able to describe the type of complications. (e.g.- Vaginal bleeding during pregnancy or delivery, Severe head aches and blurring of visions, Under/Low weight before pregnancy, Low weight gain during pregnancy, Anaemia/Severe Pallor, Previous history of miscarriage/abortion, Previous history of Caesarean delivery, Fever with chills, prolonged labour and convulsions etc). Some ASHAs were unable to do so. About 15% of ASHAs from Nayagarh, about 6% from West Bengal (11.5% from Birbhum) and 4% in West Singhbhum, Jharkhand could not define the nature of complications.

Whether the choice of facility for referring of complicated cases was appropriate, is difficult to state from the data. In complications a referral to a nearby government facility that could manage it seems to have been the usual choice. However on the question of whether the ASHA escorted women to the facility; far fewer of women with complications were escorted, ranging from 20% to 40%. Perhaps it was not possible for them to escort when the complication arose. There was no perception that it is more important to escort pregnant women with complications to the facility. This would need to be explored further.

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Supporting home delivery

Amongst these last two newborns, those from home deliveries were found to be highest in West Bengal with 37% (Malda – 46%), Jharkhand with 32% (Dhanbad: 40%), Assam with 22% (37% in Karimganj), Bihar with 12% (16% in Khagaria) and low in Orissa – 6% and 2% each in Andhra Pradesh and Rajasthan while in Kerala it was as low as less than 1% (0% in Wayanad). This does not mean that home deliveries were low- it means that support to babies in institutional delivery were higher and points to the fact that in most districts, babies of home delivery received less of ASHA's attention.

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Providing the birth companion service function

Escorting women to the institution at the time of delivery was not envisaged in the guidelines as ASHA's primary role, but it has emerged as one of the key functions of ASHA. It is also being promoted under JSY scheme as ASHA is entitled for an incentive if she accompanies women to the institution at the time of delivery and in many states this is the single biggest source of earnings.

In the last two newborns, for whom ASHA stated that she provided care and who went to institution, 75% ASHAs had escorted women to the facility at the time of delivery in Jharkhand (79% in West Singhbhum), but only 49% had done so in Bihar, 45% in Orissa, 43% in Assam (35% in Karimganj),

43% in Rajasthan (46% in Banswara), and 37% in Andhra Pradesh (42% in East Godavari). However these figures were very low in Kerala with 12% (8.7% TVM) and only 7% in West Bengal (4% in Birbhum).

No other public functionary was available for this role. Instances where ANM accompanied women were reported to be very low- in the 1% to 5% range in all districts except for a 17% in Andhra Pradesh (30% in East Godavari). Figures for AWW accompanying pregnant women were even lower again the highest being a 6% in Andhra Pradesh and a 4% in Jharkhand.

Curiosity made us ask whether the ASHA was supplementing the family role or substituting for it. The proportion of cases where husband's accompanied women – was highest in Assam with 81%, 77% in Kerala,72% in Rajasthan; 66% in West Bengal; 59% in Andhra Pradesh (64% Khammam); 43% in Orissa, 37% in Bihar and only 12% in Jharkhand (15% West Singhbhum). Figures of mothers and mother in laws accompanying were also given which were 30- 50% across all states except for Jharkhand where it was only 3%. and Rajasthan where it was highest of 70%.

Enabling JSY payments to women

Those ASHAs who were active on other fronts of care in pregnancy discussed above were uniformly active in the JSY. Being "active" was defined by the fact that the ASHA knew which women was to deliver in the next few weeks, and had counselled these women in the antenatal period. Escort by ASHA at the time of delivery was not considered an essential part of their service, but about half the beneficiaries were served by the ASHA acting as birth companion. The incentive helped; mainly by emphasising that this role was part of their job responsibility. The reporting by one third of ASHA that they performed a function of helping the pregnant woman to get her JSY financial package, out of a sense of social assistance is a welcome contributory factor and one which reaffirms the ASHA's agency and perception of her responsibility. Help in getting the JSY money has become one of the major services that ASHA is providing.

If we look at the record of the last two newborns seen by ASHAs, it turns out a) that most ASHAs in most states do visit newborns on the day of birth irrespective of local policy directives and lack of incentives b) even those who do not visit on the same day, do visit within the first week and c)there are huge divergences even within states on the pattern of visits- indicating what is apparently a random way in which a best practice diffuses and gets established as a dominant practice on the ground- quite autonomous of the intentions of the policy makers and strategists.

B) Visiting the Newborn

One interesting aspect was on ASHAs visit to newborns. It is interesting because at policy levels there is considerable controversy about the desirability, feasibility and effectiveness of such visits. On the date of the survey no such policy had been rolled out nationally, despite this being a part of the XI Five year Plan and it being a prominent line in the ASHA guidelines of 2006. Newborn care was only one of the many general messages in the training books. However in the promotion of the programme by its mentors to its practitioners, the message of visiting newborn both drawn from Gadchiroli experience and from the Mitanin experience and from sound public health knowledge had diffused to a considerable extent.

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huge divergences even within states on the pattern of visits- indicating what is apparently a random way in which a best practice diffuses and gets established as a dominant practice on the ground- quite autonomous of the intentions of the policy makers and strategists.

Of the ASHAs who named the last two newborns whom they have provided services, 74% in East Godavari visited newborns on the same day and only 10.6% visited later whereas in Khammam district of the same state only 21.7% visited in the first day, with 43% visiting subsequently. In Kerala where such visits may not be needed, and among the fully paid ASHA of Rajasthan, visits on the first day are negligible. In West Bengal, 14% of ASHAs visit on the first day, and 24% visited on second day of birth. While 49% ASHAs visited during the first day in Jharkhand, 27% did so in Bihar. In Assam and Orissa, first hour visits were the highest with 62% and 54% respectively.

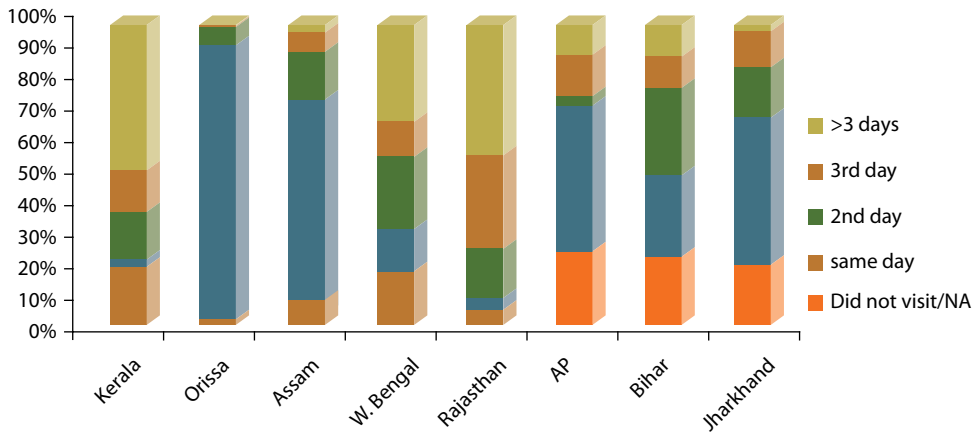

Figure 11: Newborn visits by ASHA *(N - Kerala-399, Orissa-390, Assam-400, West Bengal-353, Rajasthan-382, AP-368, Bihar-385 and Jharkhand-357)*

During the visit, the activities that the ASHA stated as doing also varies- as is to be expected for a message that permeates via diffusion rather than being actively taken forward. Some states report only counselling as the main activity. This could mean either a passively passed on message or active promotion of positive behaviour. The role played by ASHA in weighing the baby, or facilitating early weighing of the newborn and the nature of action taken on low birth weight could vary dramatically across the states. For example Rajasthan which had the lowest figure for visiting on the first day has the highest incidence of ASHAs having to weigh the baby themselves, whereas Assam which had the highest figure for first hour visit has a very low role of ASHAs in weighing the baby. However in the state of Andhra Pradesh - where 85% babies were weighed on the same day of birth and in 32% of all cases ASHA got the machine and weighed the baby herself while in another 23% instances she asked the AWW to weigh the baby. In Jharkhand 38% babies were weighed on the first day with 7.6% cases where ASHA weighed the baby herself and in 22.1% AWW took the weight. In Kerala 95% babies were weighed on the same day while it was 74% in Rajasthan, 77% in Assam while in West Bengal, Orissa and Bihar nearly 50% were weighed on the same day, mostly by health staff at the institution.

C) Care for the Sick Newborn

In Angul, 69% of ASHAs attended on a sick child and a similar proportion of 65% visited newborn during the first hour. In Assam, Jharkhand, Khammam in Andhra Pradesh; Nayagarh in Orissa, and Bihar also a similar directly proportionate pattern can be seen between the first visits made on the same

day and the newborns referred. However 64% of ASHAs in East Godavari did not attend on or refer any sick newborn in last six months; which is the reverse of trend with respect to newborn visits (74% first day visits in East Godavari). About one fifth of ASHAs in many districts are active on this score. We would see the content of the interaction during the newborn visit in the service user responses in the second section of this chapter.

Of the most recent referrals made or sick newborn attended, ASHAs reported referring (Andhra Pradesh – 53; Assam – 189, Jharkhand- 82, Kerala – 188, Orissa – 99, Rajasthan – 90, West Bengal – 110 and Bihar – 105) all these newborns to the public health institutions as well as to the private sector. Referrals to SHC were highest in West Bengal – 48% (57% - Birbhum); followed by Jharkhand with 24% (56% in Dhanbad); 13% in Rajasthan (24% Banswara) and Assam; 9% in Andhra Pradesh and only 3% each in Angul and Bihar and 2% in Kerala.

More than 85% the referrals were made to the public sector, but some referrals were made to the private sector. The percentages of referral to private sector were very low – 9% in Jharkhand (12.5% Dhanbad); 5% in Assam and West Bengal (9% in Malda) and Andhra Pradesh (11% in Khammam), 2% in Angul-Orissa and Banswara- Rajasthan except for Bihar where it was the highest with 22% (28% in Khagaria). 3% ASHAs from East Godavari and 4% from Bihar even referred to private unqualified providers.

Care for the sick child is another area in which the ASHA is functional. Just as in the case of newborn visit- the policy framework has been ambiguous on this areas- giving some training on this area – for example on diarrhoea or ARI, but not providing adequate skills nor monitoring and supporting this work.

D) Immunisation

Another major area of functionality is the monthly immunisation sessions attended by ASHAs. In a three month period the minimum they should have attended was three sessions- and where there are more than one Anganwadi in their area- upto six sessions in a three month period. Across states non performance on this score is minimal. The highest non functionality on this key expectation is 16% from Malda district, followed by 6% in Angul and 5% each in West Singhbum and Khammam and upto 2% everywhere else. This may represent the current non-functional ASHA or ASHA drop-out figure, more than any other single indicator.

E) Care for the Sick Child

Care for the sick child is another area in which the ASHA is functional. Just as in the case of newborn visit- the policy framework has been ambiguous on this areas- giving some training on this area – for example on diarrhoea or ARI, but not providing adequate skills nor monitoring and supporting this work. Unlike JSY and immunisation day functions, this like newborn visits depends more on diffusion of positive practices, facilitated or hindered by factors difficult to assess.

F) Family Planning

How active is ASHA in promotion of contraception? The question addressed "successful" referrals for IUD insertions, male and female sterilisations. Successful is understood to be a referral which resulted in the procedure being done.

In almost every district except West Singhbum and Nayagarh over 50% of ASHAs had promoted female sterilisations successfully, at a rate higher than at least one per month. Even in West Singhbum of Jharkhand, where it is lowest, 29% of ASHAs have promoted at least one case in six months. Higher successful referrals seem to be in the states where fertility rates are declining, and relatively less in those states where the need is more. Thus in Kerala 85% of ASHAs are active in this work, in West Bengal it is 88.5% with almost 12% referring about 2 sterilisations per month, in Andhra Pradesh it is 84%, in Rajasthan it is 77.5%, in Bihar it is 74%, in Orissa it is 64.5% and in Assam it is 60% and in Jharkhand it is only 47.7%- with one of the districts having only a 32% of ASHAs functional on this front. Other than in West Bengal and Bihar no state has a successful referral rate of above 2 per month of more than 18%.

Why is this so? Is it because there is a lesser demand? Or is it because there is a constraint in supply of services? Why would Assam where the ASHAs are very functional otherwise not show a higher functionality in this activity as well? One argument is that the policy framework is not as visible at the local level and in these districts family planning had a low priority. But a counter to this is that ASHAs are active in other functions like newborn care which were not currently prioritised at the policy level. Could it be that they were going by the felt needs in society and their skills?

If we turn to male sterilisations and IUD insertions, we again see that the performance of the ASHA relates closely to what we know about the availability

Table 13: Family planning cases promoted "successfully"- as reported by ASHA

	IUD – in last six months				Female sterilisation				Male sterilisation		
	Up to 5	10-Jun	>11	0	Up to 5	10-Jun	>11	0	Up to 5	>6	0
Kerala	**54.5**	**2.5**	**1**	**42**	**73.5**	**10.5**	**1**	**15**	**12.5**	**0.5**	**87**
Trivandrum	54	0	2	44	69	11	2	18	4	1	95
Wayanad	55	5	0	40	78	10	0	12	21	0	79
Orissa	**16.5**	**7.5**	**4.5**	**71.5**	**40.5**	**16**	**8**	**35.5**	**1.5**	**0.5**	**98**
Nayagarh	18	10	7	65	31	10	5	54	1	1	98
Angul	15	5	2	78	50	22	11	17	2	0	98
W. Bengal	**39.1**	**4.9**	**1.6**	**54.3**	**25.5**	**17.9**	**45.1**	**11.4**	**23.9**	**5.9**	**70.1**
Malda	37.1	7.2	1	54.6	33	14.4	40.2	12.4	19.6	2.1	78.4
Birbhum	41.4	2.3	2.2	54	17.2	21.8	50.5	10.3	28.7	10.3	60.9
Assam	**20**	**2**	**2.5**	**75.5**	**42.5**	**13**	**4.5**	**40**	**9**	**2**	**89**
Dibrugarh	8	2	2	88	32	14	6	48	8	4	88
Karimganj	32	2	3	63	53	12	3	32	10	0	90
Rajasthan	**22**	**0.5**	**1.5**	**76**	**65**	**10.5**	**2**	**22.5**	**6**	**1.5**	**92.5**
Banswara	18	0	1	81	57	4	2	37	6	1	93
Bundi	26	1	2	71	73	17	2	8	6	2	92
AP	**5.5**	**2**	**1.5**	**91**	**59**	**18**	**7**	**16**	**13.5**	**0.5**	**86**
East Godavari	10	1	3	86	58	17	7	18	25	1	74
Khammam	1	3	0	96	60	19	7	14	2	0	98
Bihar	**11.5**	**2.5**	**0.5**	**85.5**	**38.5**	**20.5**	**15**	**26**	**1.5**	**1.5**	**97**
Khagaria	2	0	1	97	41	25	12	22	2	2	96
Purnia	21	5	0	74	36	16	18	30	1	1	98
Jharkhand	**16.8**	**4.1**	**6.1**	**73.1**	**35.5**	**10.7**	**1.5**	**52.3**	**11.7**	**2**	**86.3**
Dhanbad	19	6	10	65	42	18	3	37	5	1	94
W. Singhbhum	14.4	2.1	2.1	81.4	28.9	3.1	0	68	18.6	3.1	78.4

of services and active nature of the programme in these states. Except 24% in West Bengal (20% - Malda and 29% in Birbhum) the figures of upto 5 successful referral for Male sterilisation are very low for other states. E.g. – it is 14% in Andhra Pradesh (3% in Khammam), 13% Kerala (4% in TVM), 12% in Jharkhand (5% in Dhanbad), 9% in Assam, 6% in Rajasthan, 2% each in Orissa and Bihar. Only in Birbhum in West Bengal do 10% of ASHA report a high referral rate of over 2 per month.

Similarly Kerala has the highest percentage of ASHAs (55%) who could successfully refer upto 5 women for IUD insertions in last six months. This is followed distantly by West Bengal with 39%, 21% each from Assam and Rajasthan, 17% each from Jharkhand and Orissa, 12% in Bihar and only 6% from Andhra Pradesh (1% Khammam). ASHAs who reported upto 10 such successful referrals in last six months were highest in Orissa where 8% ASHAs (10% in Angul) followed by 5% in WB, 4% in Jharkhand and 3% in Bihar while for other states this was less than 2%.

It is clear that one commonly hurled charge about the ASHA programme, that they become touts for the private sector, has absolutely no basis. In fact, at best, only a small proportion of the less than 10% could likely be doing so.

IV. Choice of Private Facility and Private Tie-ups

All ASHAs who recognised a complication in pregnancy made a referral- which is good news indeed. About 10% of ASHAs or less made the referral to a private sector hospital, in all but four districts. Two of these, (Dhanbad and Khammam) had 11.8% referral response, West Singhbum had 21.6% while Khagaria shows the highest rate of 30% referral to the private sector.

It is clear that one commonly hurled charge about the ASHA programme, that they become touts for the private sector, has absolutely no basis. In fact, at best, only a small proportion of the less than 10% could likely be doing so. The majority of private sector referrals occur in places where public sector service provision is known to be weak- Khagaria, West Singhbum etc.

This pattern of private sector referral holds true for referral in cases of sick children and newborn also. Of the last two newborns to whom ASHA provided services, those born in private facilities were highest in Andhra Pradesh; approximately 39.7%, followed by Kerala at 27.6%; Jharkhand 13% (18% in Dhanbad), and only 8% in Assam and less than 5% in WB, Orissa, Rajasthan and Bihar. 4% of ASHAs also stated deliveries by the unqualified private provider in Dhanbad, for other eight districts it was less than 1% and even 0% in TVM- Kerala, WB, Bihar, and Karimganj: Assam; Banswara - Rajasthan.

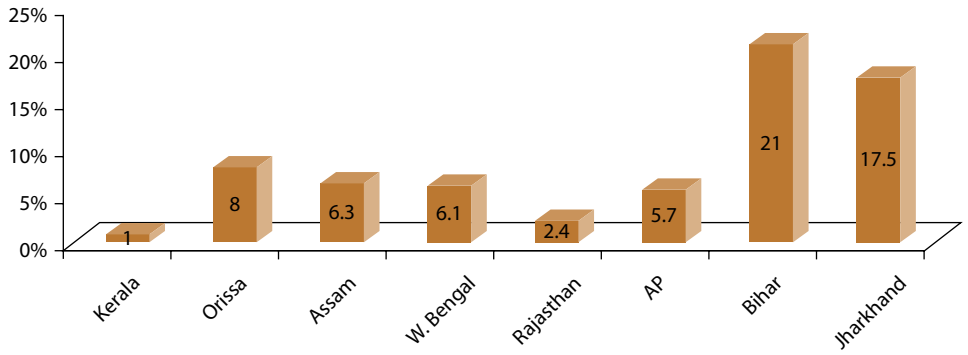

Figure 12: Private share of referral by ASHA - for pregnancy related complications *(N for Kerala-103, Orissa-113, Assam-80, West Bengal-66, Rajasthan-84, AP-70, Bihar-81, and Jharkhand-80)*

The reason for the choice of private sector was stated as family's preference by 74% ASHAs from Kerala (81% TVM), 60% from Andhra

Pradesh (78% - Khammam), 57% from Malda - West Bengal (0% in Birbhum), 57% from Banswara - Rajasthan (0% - Bundi), 44% from Jharkhand, 39%- from Assam (45% - Dibrugarh) and 22% from Angul – Orissa (0% in Nayagarh).

The second common reason was the non availability of any functional public facility in Jharkhand – 33% (42% Dhanbad); 33% in Khagaria in Bihar; Kerala with 21% (26% Wayanad); Andhra Pradesh with 19% (23% East Godavari); Orissa with 15% (25% - Nayagarh) and Karimganj in Assam with 27%.

Was there a commission paid to the ASHA for a private sector referral? We asked this question directly and we got some direct response. In West Singhbum of Jharkhand, 17.5% of ASHAs had received some commission, 11% in Bundi, and then 9% in East Godavari with all the other districts having less than 6% receiving a commission.

V. Community Mobilisation

Beyond provision of facilitation and care to the individual user, the ASHA is expected to function as a community mobiliser or activist. This refers to her function of building community rapport and more importantly, enabling the realisation of the health and entitlements of the community especially those of the marginalised and vulnerable. One of the vehicles for her to achieve this role is her participation and leadership in the Village Health and Sanitation Committee. In Chapter 2 we have already discussed the status of the Village Health and Sanitation Committees. We also discussed the recognition of social exclusion and the reach of the ASHA to marginalised households.

Here we present findings of the evaluation that highlight the sense of agency that the ASHAs have been able to exercise in their work with communities. The activist dimension of ASHA is enshrined in her name. In her training, until she was trained in Module 5, there was little discussion on issues such as empowerment, choice, agency and activism. Module 5 made a conscious effort to correct this gap but was introduced only in 2009. Even this was only in the states of Orissa, Assam, West Bengal, Andhra Pradesh and Jharkhand.

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Table 14 illustrates modest levels of mobilisational activity among the ASHA. Much of this reflects spontaneity. These women are active agents of change and given the opportunity and space some of them at least are functional in community mobilisation for ensuring service access, mobilisation for water and sanitation, taking action on domestic violence, and against alcoholism. The levels vary substantially across the states, but clear linkages with the level of support and training emerge.

These women are active agents of change and given the opportunity and space some of them at least are functional in community mobilisation for ensuring service access, mobilisation for water and sanitation, taking action on domestic violence, and against alcoholism.

It appears the mobilisational tasks on which ASHA are most functional are-

1. Water and sanitation, ranging from 17% in Bihar to 68% in Kerala, with the modal average being 54%. In Andhra Pradesh, Assam, Rajasthan, Jharkhand the levels show over 50% of ASHA as being active, in such mobilisation.
2. Ensuring availability of services from the h ANM/AWW, with a modal average of 34% across the states. The highest in this is reported by Orissa, followed by Jharkhand and Assam.
3. Mobilisation against domestic violence has a modal average of nearly 18%, ranging from 29% in Rajasthan to 8% in Bihar.

Table 14: Community mobilisation

	Ensuring availability of services from ANM/ AWW/	Picket-ing of alcohol shops	Ensuring participa-tion in ICDS food production	PDS shop regula-tion and demand generation	Water and sanita-tion facilities	Forest rights and environ-mental issues	Mo-bilisation against domestic violence	Adult and women educa-tion	Others	Not active
Average (Modal)	34.25	9.95	17.6	13.5	54	7.05	17.6	21	2.25	24
Kerala	61	9	41.5	11.5	68	11	28	23	0	10
Orissa	45.5	14	34	7	47	7.5	19	10	1	18.5
W. Bengal	15.2	10.9	19	3.8	23.9	3.8	12	12	4.9	56.4
Assam	33.5	7	11.5	1.5	56	2	14.5	6.5	0	31.5
Rajasthan	26	11	14.5	6.5	55.5	11	29	28.5	10	24.5
AP	61.5	26	23	20.5	52.5	16	25.5	27.5	0	23.5
Bihar	19.5	3	5.5	2	17	2	8	19	3	57.5
Jharkhand	35	7.1	16.2	11.7	61.9	6.6	16.2	24.4	1.5	20.3

4. Enabling access to ICDS the range was from 42% in Kerala to 6% in Bihar (18% - Modal average).
5. Picketing against alcohol was reported by less than ten percent of the women, but was nearly 33% in East Godavari district of Andhra Pradesh, probably given the state's history and background of women's involvement in the anti arrack movement.

Nearly 58% of ASHAs in Bihar reported not being active in any of these issues, likely related to the character of the programme fashioned by the implementers, or the lack of training in Module 5. West Bengal also reports no activity by a similar proportion and reflects a lack of mobilisational character in the programme. In conclusion therefore we see that nearly one fifth of the ASHA are active on community mobilisation, and this is as much to do with background characteristic of the state and district context and her own agency. This is not a high achievement but it shows the potential to build upon this dimension if we so plan.

In conclusion therefore we see that nearly one fifth of the ASHA are active on community mobilisation, and this is as much to do with background characteristic of the state and district context and her own agency.

How functional were ASHAs in making an effort to reach the marginalised sections. We have already noted earlier (Chapter 3) that over half the ASHAs perceived the existence of marginalised groups and one third perceived social barriers in reaching out to them.

Did they make any efforts to overcome these barriers? In order to address the issue of social exclusion, frequent household visits to the marginalised households was reported as the most common step taken by ASHAs except for Bihar where steps taken to facilitate use of AWC and SHC services was the most common activity. A high percentage of 68% ASHAs from Kerala reported making more frequent household visits followed by 43% from Assam and 26% from Andhra Pradesh. For the remaining states the same was reported by less than 15% of the ASHAs. Similar trend can be observed for organising health camps in these areas and steps for enrolling for AWC and SHC services across all states but with much lower frequencies. Overall ASHAs from Kerala are most active in taking measures for reaching out to the marginalised sections followed distant by Assam and Andhra Pradesh.

Table 15: Social exclusion

States	% of ASHAs reporting marginalised households in the village	% of ASHAs who reported marginalised households and who find it difficult to access marginalised households	% of ASHAs who took steps - Organising health camps for inclusion of marginalised sections	% of ASHAs reporting frequent house hold visits to- marginalised sections	% of ASHAs who took steps- to enroll marginalised sections in AWCs/HC-	% of ANMs who said that every one in the village is benefitted from ASHA services	% of AWWs who said that every one in the village is benefitted from ASHA services
Kerala	87.5	25.1	60.5	68	41	70	59.5
Orissa	97	30.9	6.5	9	0	92.2	94.5
W. Bengal	72.3	24.1	5.4	12.5	4.9	79.2	71.9
Assam	85	39.4	14.5	25.5	15.5	72	75.4
Rajasthan	52.5	41	5	11.5	7	76.1	80.4
AP	87.5	18.9	21	43	22.5	82.4	81.3
Bihar	72	25.7	2.5	15.5	19	81.8	79.8
Jharkhand	60.9	35.8	4.1	11.7	7.6	82.4	79.3

Perceptions of ANMs and AWW on the existence of marginalisation is limited and much less than that of the ASHA- and the general perception is that ASHA serves "everyone in the village" equally and there is no special concept of affirmative action to reach the weakest. More ASHAs in contrast report sections which have difficulty in accessing health services, as well as report sections that they have problems in accessing.

Are ASHAs emerging in larger leadership roles?

It is too early to comment, but there is an opportunity here. Interesting to note that ASHAs do not stop being ASHAs when they become an elected Panchayat member. About 9% of ASHA reported being a Panchayat member, with the highest being 20% from Orissa followed by 18% from Andhra Pradesh, 12% from Bihar and 10% from West Bengal while in the other four states it was only upto 5%.

Section 2: Assessing Functionality – Service User's Response

The previous section reported on findings related to the functionality of the ASHA from the responses of the ASHA herself, i.e. her reflections and perceptions on her roles, her activities and her reach. What ASHAs state they are doing- may not be actually what they are doing on a routine or widespread basis. This was explored by interviewing service users.

This section reviews the functionality of the ASHA from the point of view of the service users. The survey interviewed two categories of service users, listed in the table below.

Service user category A – Mother of a six month old child who have received services of ASHA during pregnancy and for newborn car	Service user category B – Mother of a child between 6 months – 2 years of age who has been ill in last one month
■ Andhra Pradesh – 671 ■ Assam – 791 ■ Bihar – 757 ■ Jharkhand – 636 ■ Kerala – 800 ■ Orissa – 769 ■ Rajasthan – 726 ■ West Bengal – 711	■ Andhra Pradesh – 359 ■ Assam – 387 ■ Bihar – 289 ■ Jharkhand – 345 ■ Kerala – 397 ■ Orissa – 351 ■ Rajasthan – 366 ■ West Bengal – 341

In states like Assam, about 71% of women were counselled on IFA tablets, and 70% on institutional delivery, with 67% having one medical check up. However, only 46% of beneficiaries reported having been counselled on initiation of breast-feeding, 27% reported received any post partum care advice, and only 13.4% said they had received any advice on nutrition.

A) Care in Pregnancy

The responses show that most beneficiaries/service users across all states had been met more than thrice during the antenatal period. In both districts of the better performing states like Andhra Pradesh and Kerala, Angul of Orissa and Dibrugarh of Assam, less than 10% of beneficiaries had been visited less than twice, whereas in other states this figure rises up to 20% in both districts of West Bengal and Nayagarh; and in other districts it is reported by 20-40% of service users. During these visits counselling was provided on the following topics. These topics are listed in declining order of the proportion of beneficiaries who recalled being provided with counselling or educational inputs by the ASHA.

In states like Assam, about 71% of women were counselled on IFA tablets, and 70% on institutional delivery, with 67% having one medical check up. However, only 46% of beneficiaries reported having been counselled on initiation of breast-feeding, 27% reported received any post partum care advice, and only 13.4% said they had received any advice on nutrition. On cautions for a home delivery only 5.3% received any tips on the 5 cleans. Advice on JSY benefits were a good 10% lower than advice on institutional delivery. Significantly fewer women from Karimganj reported receiving counselling on all these aspects. The focus appears to be on providing information on JSY benefits.

This is the also the pattern in Rajasthan, Jharkhand and Orissa except that the counselling over visiting a doctor (34% Dhanbad) and post partum care is seen less frequently in Rajasthan and Jharkhand. In Orissa the figures are consistently higher for each response- the lowest being for five cleans in case of home delivery with a 42% user response and 58% for family planning advice. In Bihar counselling on JSY benefits was reported by maximum beneficiaries – 70% followed closely by the same four categories – advice on IFA, visiting doctor, institutional delivery and breast feeding. Other areas received much less attention.

In Andhra Pradesh post partum care appears to be one of the areas of counselling most neglected, while it was home delivery in Rajasthan, Kerala and West Bengal. On most other parameters ASHAs do seem to be providing active counselling. However inter district variations were quite high in Andhra Pradesh with lower percentages from Khammam on almost all areas. Counselling on the cleans of home delivery is among the lowest across states second only

to advice on post natal care. It is not a major a concern in Kerala and Andhra Pradesh where almost all respondents have had an institutional delivery, but it is a problem in the substantial number of home deliveries that have taken place in the other states- even though they were users of ASHA services!!

In response to a query from users on who they contacted for advice on pregnancy related complications, over 71% across all districts consistently reported that it was ASHA which was not surprising, since the users had been chosen purposively. Interestingly, only half reported seeking advice from the ANM, followed by fewer women who reported that they would seek advice from the Anganwadi worker, Dai and local healers.

Of all women who reported going to an institution for delivery, ASHA escorted over 70% in ten districts. Only 10% of service users from both districts of Kerala and West Bengal reported instances where ASHA acted as a birth companion while it was 30% in Khammam and 53% in Banswara. In states like Jharkhand, Orissa and Bihar ASHAs played a more important role as in these districts, percentages of husbands and other relatives accompanying was about half than that of ASHA.

Table 16: Issues on which ASHA provided any advice during pregnancy to service user category A

	Visiting doctor for weighing, BP checkup & TT	Advice regular consumption of IFA	Advice on institutional delivery	JSY benefit	Home delivery care (Five cleans)	Immediate initiation of breastfeeding	Family planning advice	Advice on nutritious food	Post natal care	None
Kerala	**84.5**	**87.4**	**76.5**	**77.5**	**30.4**	**70.1**	**61.8**	**67.6**	**56.8**	**0.9**
Trivandrum	78	84.3	72	78.8	35.3	64.5	60.8	62	46	1.3
Wayanad	91	90.5	81	76.3	25.5	75.8	62.8	73.3	67.5	0.5
Orissa	**94.8**	**81.8**	**86.2**	**80.9**	**42.3**	**75.6**	**58**	**69.7**	**61.6**	**0.7**
Nayagarh	94.9	84.7	85.8	85.2	44.9	83.9	58.6	76.6	67.5	1.3
Angul	94.7	79.1	86.6	76.8	39.8	67.8	57.4	63.2	56.2	0
W. Bengal	**84.7**	**90.6**	**85.1**	**64.6**	**29**	**75.1**	**54.3**	**74.8**	**55**	**0.4**
Malda	92.6	85.4	84.8	54	26.6	76.1	55.6	75.5	53.2	0.5
Birbhum	76.3	96.7	85.6	76.6	31.8	74.2	52.6	73.9	57.1	0.3
Assam	**66.9**	**71.4**	**69.9**	**54.6**	**5.3**	**45.5**	**35.5**	**13.4**	**26.9**	**4.2**
Dibrugarh	94.9	82.7	73.3	60.6	8.9	40.5	58.5	15.3	42.7	1.5
Karimganj	39.2	60.3	66.6	48.7	1.8	50.5	12.8	11.6	11.3	6.8
Rajasthan	**57.3**	**83.2**	**67.4**	**61.3**	**7**	**53.7**	**16.8**	**29.2**	**9.2**	**4**
Banswada	59.3	91.1	67.4	70	6.2	54.9	13.9	22	7.4	3
Bundi	55.5	76.3	67.4	53.7	7.7	52.7	19.3	35.5	10.8	4.9
AP	**94.5**	**90.8**	**75.3**	**76**	**54.5**	**73.2**	**68.2**	**70.9**	**26.7**	**0.3**
E. Godavari	97.9	95.9	90.2	90.5	57	82	80.9	78.1	39.2	0.3
Khammam	89.8	83.7	54.8	56.2	51.2	61.1	51.9	61.1	9.5	0.4
Bihar	**68.6**	**69.1**	**64.1**	**69.5**	**10.6**	**55**	**21.3**	**38**	**13.3**	**4**
Khagaria	72.1	69.4	54.1	65.6	11.7	48.6	20.8	34.2	16.7	6
Purnia	65.2	68.8	73.4	73.1	9.5	60.9	21.7	41.7	10.2	2
Jharkhand	**47.2**	**83.3**	**75**	**64.2**	**34.7**	**71.1**	**45.3**	**52.7**	**32.2**	**3.6**
Dhanbad	34.4	80.3	77.6	64.5	42.5	73.2	41.5	48.5	39.5	4.3
WS	58.5	86.1	72.7	63.8	27.9	69.1	48.7	56.4	25.8	3

Of those users who reported receiving JSY payments, the ASHA again emerges as playing the major role, in facilitating this process with 81% in Andhra Pradesh (55% Khammam), 72% each in Assam (55% in Karimganj) and West Bengal (53% Malda); 66% in Jharkhand; 50% in Orissa; 42% in Bihar (27% in Purnia); 29% in Kerala (33% in Trivandrum); 24% in Rajasthan (32% in Bundi). The ANM is a distant second, and all the other potential players not being active on this aspect.

One interesting difference between the response of the ASHA and the user, is that most women report having started breastfeeding in the one to four hour period and not in the first hour. This also matches with the response that in a large percentage of such users, the ASHA was present when breast-feeding was initiated.

B) Care for the Newborn

In terms of newborn care, though visits in the newborn care period have been taking place, these visits represent a missed opportunity, for the delivery of newborn care. Thus while the score is good for counselling on initiation of breastfeeding (over 75%) and for exclusive breastfeeding (over 60%); more than half of the mothers with children under six months, said the ASHA had not counselled them on keeping the baby warm, birth registration, or discussed spacing contraceptives.

ASHAs were present during the weighing of the child in about 50% to 93% (highest 93% in Orissa and lowest of 21% in Kerala). About 40-50% of ASHAs made more than two visits in the first month. Such "over two" visits in the newborn period are lowest for Bihar followed by West Bengal and then Jharkhand and Rajasthan and then Kerala and Assam. The highest is in Orissa in Andhra Pradesh, but that too is only in 58% of cases. As per the mothers interviewed over 90% children received vaccination (BCG and Polio) indicating that ASHAs have made an important contribution to promoting the first immunisation with over of 50% of ASHAs either directly or indirectly enabling mothers to attend the immunisation day.

One interesting difference between the response of the ASHA and the user, is that most women report having started breastfeeding in the one to four hour period and not in the first hour. This also matches with the response that in a large percentage of such users, the ASHA was present when breast-feeding was initiated. In practical terms whether breast feeding started in first hour or in first few hours this may make little difference- but it is indicative of the timing of the ASHA's visit and the role she plays.

C) Care of Sick Newborn

In those mothers who had a newborn with any symptoms or problems indicating ill-health the study included questions to assess who they sought advice from, who helped identify the illness, and the nature of the advice. The illness was noticed by the mother/family in about half the instances. The next most frequent source of identification of illness signs was the ASHA. AWW activity was much less than half that of the ASHAs on this score, as reported by potential users. In all states it was less than 15% for Anganwadi workers except for Jharkhand and Andhra Pradesh where it was 25% and 28% respectively. On the other hand identification, even by ASHAs was low and only over 30% of ASHAs made any contribution to this aspect, with the highest in Andhra Pradesh with 56% (64% Khammam), followed by rest of the states within the range of 30-45% while Assam shows only 26% (35% Dibrugarh) such cases. In seeking help at the village level also, ASHA (40-60% with only Andhra Pradesh having

The next most frequent source of identification of illness signs was the ASHA. AWW activity was much less than half that of the ASHAs on this score, as reported by potential users.

79%) and not the Anganwadi worker was seen as the first resource to help. When it came to treatment, it could be the PHC or the sub-centre in the public facility, or it could be private facility that they went to- the difference appears to be made only based on the facility that is available.

D) Immunisation in the Young Child

ASHAs have been active and effective in immunisation promotion with those families that they have reached. Above 98% of mothers with children less than two years who had availed of ASHAs services for sickness of the child also report full immunisation of the child. The ASHA, the ANM and the AWW are all seen as facilitators and promoters, but with the first two playing a more important role than the role of the Anganwadi worker.

Table 17:

	Care of newborn and sick newborn			Immunisation and childhood illness management				
	Service user category A			Service user category B				
	% of user A who were visited more than two times in first month after delivery	% of user A where ASHA was present during weighing of the newborn	% of user A who reported that the newborn was sick in 1st month and ASHA helped in identifying danger signs of the newborn	% of service user – B child who received any vaccination	% of user B who stated that unisation was facilitated by ASHA	Of those user Bs who had diarrhea, the % in whom ASHA helped in some way	User Bs who had diarrhea the % to whom ASHA gave ORS from her kit	Of those user Bs with signs of ARI, the % in whom ASHA helped in some way
Kerala	**43.3**	**20.8**	**41.3**	**97.7**	**93.8**	**92.1**	**82.5**	**93.1**
Trivandrum	53	34.8	29.3	97	93.2	86.8	82	86.7
Wayanad	33.5	6.8	56.3	98.5	94.4	98.1	83	100
Orissa	**57.1**	**93.4**	**43.4**	**99.7**	**78.3**	**90.3**	**82.9**	**97**
Nayagarh	41.9	93.8	48.5	99.4	86.2	93.4	84.6	94
Angul	71.3	92.9	36.1	100	71.7	89.7	81.7	97.9
W. Bengal	**36.6**	**49.5**	**29**	**99.7**	**90.3**	**82**	**51.6**	**75**
Malda	39.6	67.3	25.4	99.4	85.5	68	38.6	61
Birbhum	33.3	29.4	37.5	100	95.2	95.7	63.8	80
Assam	**48.8**	**55.2**	**26.1**	**98.2**	**69.5**	**70.8**	**54.2**	**64**
Dibrugarh	62.6	47.8	34.5	100	42	65.2	38	58
Karimganj	35.2	62.6	14.1	96.5	96.4	76	69	77
Rajasthan	**37.9**	**71.6**	**38.6**	**98.1**	**93.9**	**66.7**	**56**	**64.2**
Banswada	32.6	65.9	39.7	96.6	92.9	65.9	58.5	64.2
Bundi	42.4	76.6	37.5	99.5	94.8	67.2	54	64
AP	**57.1**	**66.9**	**56.2**	**98.3**	**78.2**	**85.2**	**71.6**	**96**
E. Godavari	59.8	77.3	64	97.8	75.3	84.1	72.7	100
Khammam	53.4	52.7	46.2	98.9	81	86.5	70.3	94
Bihar	**31.6**	**70.4**	**36.6**	**99.7**	**89.6**	**70.9**	**26.7**	**67**
Khagaria	30.6	62.6	32.5	100	85.1	63.3	26.4	62
Purnia	32.5	77.7	47.3	99.3	94.3	90.9	27.3	80
Jharkhand	**37.6**	**78.3**	**47.5**	**93.9**	**72.5**	**72.9**	**36.5**	**67**
Dhanbad	46.8	78.9	73.6	91.9	91.2	92.3	0	74
WS	29.4	77.7	34.6	95.7	56.8	69.4	43.1	61

*Note – All above figures have to be read in conjunction with the table 16 because proportions of access covered vary from state to state.

E) Illness Care for the Sick Child

In the management of illness of the children with diarrhoea ASHA acted as the main care provider in few cases while in others the role of ASHA has been modest. ASHA gave ORS in about 70-80-% of cases in Andhra Pradesh, Kerala and Orissa, 55% did so in Assam and Rajasthan while it was only 37% in Jharkhand (0% in Dhanbad & 43% in West Singhbhum) and 30% in Bihar. Referral to public facility doctor was made by over 45% ASHAs in five districts. In the remaining eleven districts it was up to 30% with the lowest being 12% in Karimganj and Birbhum. 31% from Dhanbad, 24% from Purnia, 21% from Khagaria and 13% from West Singhbhum also referred to private sector while it was less than 5% in other districts. For the management of children having symptoms suggestive of pneumonia, ASHAs provided support in about 93-97% cases in Kerala, Orissa, and Andhra Pradesh while it was 75% in West Bengal and about 65% reported the same in remaining four states. Over 90% of Service users B have sought treatment for children with these symptoms.

Discussion

The determinants of functionality, according to the framework of our analysis depend on three factors:

a) The policy framework as interpreted modulated and presented to the ASHA. Does the system present this task as being part of their job? The training and support provided are a reflection of the policy framework as perceived by the ASHA. If a task is part of the training programme and also monitored, it sends the signal that this activity is desirable and therefore it is more likely to be carried out.

b) Is there an incentive payment made for this task? Incentives provide social recognition and give value to the task that she performing, in addition to the financial gains she makes from doing this task.

c) ASHAs exercise their agency and have a motivation to serve, (often selected because she has such motivation), also have their own perceptions of community needs and are responsive to such needs. To what extent is her functionality influenced by her "agency"? Also even on routine tasks- a poorly selected disinterested ASHA who came into the programme with other expectations, or a demoralised ASHA in conflict with other staff or the community or an ASHA who has just got tired of the job, may lose her motivation and cease to be functional.

But a substantial percentage of ASHAs and her immediate supporting staff, respond to community needs in addition to what she is incentivised for, and this could be one reasons for the high degree of variation in functionality observed.

The study shows that the vast majority of ASHAs are functional- irrespective of several constraints, and contextual factors. There is however a wide variation in the exact set of tasks an ASHA carries out (range), the percentage of potential users of these services who are reached (coverage or utilisation), and the effectiveness with which this task is done- in terms of achieving desired behaviour changes, or recovery from an illness, or access to a service provided by the facility. Such a variation in functionality which occurs within districts and between districts and makes generalisation of any sort difficult. This high variation is largely a function of the fact that though at one level and ASHA is tasked with many functions, in practice she is supported, incentivised and monitored on very few tasks. But a substantial percentage of ASHAs and her immediate supporting staff, respond to community needs in addition to

what she is incentivised for, and this could be one reasons for the high degree of variation in functionality observed.

Our case studies and interviews in the first phase shows that the selection of the short-list of activities, on which she is supported by the health system, depends on the way implementers at different hierarchical levels have interpreted and modified the central guidelines, amplifying some part of the guidelines and downplaying and ignoring others. To quote one senior official "Main Aagya zaroor paalan karoonga, lekhin apne hisaab se." ("I will certainly obey orders, but by my measure"). This phenomenon was universal, though most were not so explicit or even conscious of doing it by their measure. It could be argued that the guidelines lent themselves to such interpretation; a view with which we would disagree. Or it could be argued that some of the elements of the guidelines could not be implemented as envisaged because of strong views or institutional realities at the district, block or sub-block level, a view with which we would agree, though that would not be the whole truth. The truth is that implementers - programme officers and administrators- at different levels have a framework of understanding or programme theory through which they view the programme and they choose to implement parts of the programme which are consistent with their own views and downplay other programme components.

Programme officers have a framework of understanding through which they view the programme and they choose to implement parts of the programme which are consistent with their own views and downplay other programme components.

On two tasks there is complete consensus amongst implementers that they are critical to the programme- and the structures of support are uniformly in place. Both these functions happen. They are a) the ASHA attending the immunisation day with an effort to mobilise women for ANC and children for immunisation and b) ASHA promoting institutional delivery. The latter as measured by meeting the pregnant woman for promoting institutional delivery. These two tasks occur with over 90% of ASHAs and the outreach for these two activities – as a rule, across states, is most impressive. One reason for this is incentivisation, as these are the two most consistently incentivised activities. Another reason is that this is also the most supervised elements of the programme. The third contributory factor is that this activity requires relatively little knowledge or skills or on the job supervision or any other form of support. The incentive is everything. What emerges clearly from a discussion and comparison across states is that the slower the pace of training, the lesser the investment in support structures, the greater the de-emphasis on drug supplies, the more likely that the implementers believe that the ASHA is to be limited to these two functions.

Two tasks occur with over 90% of ASHAs. One reason for this is incentivisation, as these are the two most consistently incentivised activities. Another reason is that this is also the most supervised elements of the programme. The third contributory factor is that this activity requires relatively little knowledge or skills or on the job supervision or any other form of support. The incentive is everything.

The "escorting pregnant women to the institution for delivery" is much less – as a proportion of those pregnant women who have been met by the ASHA, in those states which are non high focus and the need for such promotion is much less- Kerala (9%), West Bengal (5%) and Andhra Pradesh (53%) as compared to high focus states. This may be because the number of BPL women is low, and there is no incentive for accompanying them. At any rate, the ASHA may have not value added to the process, as most women whom they accompanied would have opted and gone for institutional delivery anyway- the rates of institutional delivery being much higher than both.

Achievements in the escort function in the high focus states, is modest – ranging from 20 to 60%. It also appears that in Bihar and Rajasthan choices have been made to meet only those women who are likely to opt for institutional delivery,

since over 90% of those they met opted for institutional delivery though they reached only 75% of the pregnant women. Most of the women they failed to meet were the women who opted for home delivery.

In Jharkhand on the other hand about half the women the ASHA met and counselled did not opt for institutional delivery- which either means merely poor effectiveness or a less incentive driven more broad based coverage. We choose the latter explanation for the following reasons: The impact on three ANC check- ups and post partum care and other aspects of pregnancy management, does not show any major improvement in Rajasthan and Bihar, as compared to DLHS-III, whereas in Jharkhand, Orissa and Assam it did show significant improvement. In these latter states the support system is able to provide training and support that indicates the importance of all aspects of care in pregnancy, whereas in some states like Bihar, the training and support was weak, and only the incentive held the programme together.

It also appears that in Bihar and Rajasthan choices have been made to meet only those women who are likely to opt for institutional delivery, since over 90% of those they met opted for institutional delivery though they reached only 75% of the pregnant women. Most of the women they failed to meet were the women who opted for home delivery.

In Kerala and Andhra Pradesh the performance on all aspects of care in pregnancy is anyway good by DLHS-III and that same figure is seen here. In West Bengal it was modest and it remains modest here. On Injection TT however West Bengal does the best- followed by Bihar. In issuing an ANC card, West Bengal does reasonably well and so too on counselling for post partum care and contraception. The counselling on post partum care must be limited by the low skill level in this area, while the excellent outcomes on contraception relate both to high knowledge levels and possibly good availability of services. In Bihar in contrast, on all these parameters- the ANC card, the post partum counselling, the counselling on contraception, and the functionality and effectiveness is low. Knowledge in post partum counselling is as in West Bengal low- but it is relatively better in contraception.

This contrast is used to make this simple point, that functionality is a resultant of the way programme theories – the subjective aspect- interact with support- in the form of payments and quality of monitoring.

We find the same pattern in newborn care. It is fortunate that the sample included Angul which acts as a best practice exemplar in this area. We can see that a high performance on newborn care has had spin off effects in all aspects of ASHA functionality- most dramatically in coverage. (there is still a last 15% to be reached!!). ASHAs also receive a more reliable, a more accountable payment and are the best paid ASHAs of all our district case studies. Newborn care is incentivised. Programme theory and practice combine with support and supervision to yield high level of functionality.

In most other states newborn visits are still upto 40% of families who are under ASHA coverage of any sort. Even this level of functionality means a large number of visits – in absolute numbers and this could have resulted in more outcomes, but then the

skills and support are just not in place- and this opportunity has not been optimally made use of.

Training on some aspects – especially child nutrition and post partum care remain very weak in Orissa and in these areas the ASHAs functionality becomes poorer. In Angul on the quality of complementary feeds none of the ASHAs knew the answers. It is worth noting, that even in Nayagarh, though nowhere near Angul, the performance on many parameters of care in newborn is much better- perhaps a reflection of the programme theory and support mechanism on Orissa.

In care in illness of the sick child, despite programme theories of implementers against any form of curative care and a lack of support, we find that at least 40% of ASHAs are being consulted. In states other than in Bihar and Jharkhand it is well above 60% - going upto 88% in Angul or 91% in Birbhum. Given the fact that there are many other informal health care providers, in these villages, even this score of 40% of ASHAs functional on this work is a step forward. There is no major private sector referral and even in Jharkhand's West Singhbum and Khagaria, this 25% of cases who do get referred to private sector could be due to the lack of alternatives, more than anything else. There is no fee for service. Referrals to RMPs are rare exceptions and this in itself should be leading to considerable savings from unnecessary and irrational treatment. Activity in this area seems to co-relate with better programme support at sub district levels from officers and local supervisors who encourage them and provide her with drug kit refills from their local supplies. But as a rule, the levels of skills are varied and even functionality is very varied and this shows that without a clear driver, various trainers and programme managers have made the best possible use of the opportunity provided. It also indicates that ASHAs themselves have shown considerable "agency" in responding to felt needs. Uniformly below the block this function of responding to the felt needs of the community and especially the sick child is felt as an urgent necessity. Effectiveness would however be constrained by lack of medicines and lack of monitoring and support- and we discuss this in the next chapter.

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Wednesday

CHAPTER 5

Effectiveness of the ASHA:
...And Outcomes of the Programme

Outcomes- or effectiveness of the ASHA are seen in terms of changes related to three categories of activity.

1. **Facilitation:** where her task consists of getting the user to a health facility or professional service provider (midwife, nurse or doctor, either public or private). Asking the woman to go to a health facility or a VHND is functionality. Whether the woman actually going to the facility and receives treatment or ANC in a VHND is effectiveness.
2. **Community level care provision:** This includes counselling and health education to prevent illness, to promote good health practices, and to respond correctly to illness. Community level care also includes diagnosis of illness and appropriate action – referral, drugs, home remedies or counselling- by the ASHA. Counselling is functionality- but an actual change in health behaviour or health practice or taking the appropriate care for treatment of an illness is effectiveness.
3. **Mobilisational:** This relates to securing entitlements, promoting collective action for prevention of disease or access to services, holding village meetings, and reaching services pro-actively to the most marginalised sections, all of which could be called the activist role. We have only explored which of these tasks ASHA was functional on. On these tasks it is difficult to measure effectiveness or outcomes- and we have not tried. However we posit that her reaching out to the most marginalised sections is one important measure of effectiveness. Therefore – coverage- or the measure of what percentage of the potential beneficiaries actually utilised her services is a good measure of effectiveness on mobilisation.

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The Determinants of Effectiveness

There are four major determinants of effectiveness? Or in other words there are four determinants of when a function carried out by ASHA achieves its outcome. These four determinants could be listed as follows:

1. **Coverage:** Does the ASHA reach all families in her area? Or are there families that are getting excluded from her services? If she fails to reach about 30% of her households and if these households are the most vulnerable, despite her being functional, we may not get the health outcomes intended.

Thus the ASHA being functional always needs a matching systems response for her to be effective.

2. **Skills:** Does the ASHA have the necessary skills, so that she can provide the quality of community level care, or counselling that would lead to a health outcome. She may make regular household visits, but if she does not have the knowledge and skills needed, it would not make a difference to health outcomes.
3. **Systems Support:** In most instances, the ASHA's actions do not lead to a health outcome unless there is a matching response from the rest of the health system. For example she can mobilise to the VHND, but the ANM should be available with necessary vaccines. She can refer the complicated case to the facility, but emergency obstetric care should be available there. She can identify the sick child with diarrhoea, ARI or malaria, but without ORS or co-trimoxazole or choloroquine tablets the child may anyway die. Thus the ASHA being functional always needs a matching systems response for her to be effective.
4. **Functionality:** In the earlier chapter we defined three determinants for functionality. If the ASHA is not motivated enough, and if the system does not encourage her to undertake this task, or signal to her in some form that her work in this area is welcome- then she would not be functional- and then of course she would not be effective.

We have already discussed functionality in the earlier chapter. We begin by discussing utilisation or coverage.

Coverage: Utilisation of ASHA's Services

To assess coverage, we followed the following methodology.

In every village from which an ASHA was selected for study a complete line listing was done of a) all mothers who had children in the 0 to 6 month age group and b) of women who had children in the 6 months to 2 year age group where there was any sickness within the last one month. Then as part of this line listing they were asked the question- whether they were met by the ASHA and in some form- including counselling – utilised her services for pregnancy care in the first case and for child care in the second.

The reason for choosing these two categories was that it would be more reasonable to focus on that section of the population, prioritised in the policy framework and for which the ASHA was trained and supported rather than the general population of the village.

Comparing the number of women line-listed in each of these categories with the expected number of women in these age groups (by applying state crude birth rates), the line listing appears to have been complete. We now have reliable estimate of the utilisation of ASHA services in the most prioritised beneficiaries.

The figures on coverage or utilisation are shown in Table 18.

Coverage can be seen to vary widely-. The two districts of Kerala, Angul in Orissa, and Birbhum in West Bengal record over 80% utilisation. The two districts of Assam and the two districts of Rajasthan show utilisation of 75% and 77% for care in pregnancy but in the 67% for care of the sick child. Bihar shows utilisation for pregnancy care by 73% in both the districts. Next with

Table 18: Utilisation of ASHA by service users A and B

	% of all women with 0 to 6 month child in the village who received any service from ASHA	% of all women with 6 month to 23 month child with an illness in last month who received any service from ASHA.
Kerala	**84.69**	**90.44**
Trivandrum	80.6	83.18
Wayanad	89.09	96.4
Orissa	**75.87**	**75.31**
Nayagarh	66.72	61.94
Angul	84.63	88.35
W. Bengal	**67.24**	**81.87**
Malda	53.18	73.55
Birbhum	86.3	91.28
Assam	**76.89**	**67.19**
Dibrugarh	73.59	59.75
Karimganj	78.43	69.74
Rajasthan	**76.43**	**67.44**
Banswara	77.06	72.02
Bundi	75.92	64.3
Andhra Pradesh	**49.9**	**76.79**
Khammam	67.68	78.43
East Godavari	42.17	73.24
Bihar	**72.01**	**45.32**
Khagaria	71.34	45.65
Purnia	72.68	45
Jharkhand	**59.67**	**46.49**
Dhanbad	55.45	44.75
West Singhbhum	63.07	47.76

utilisation in the 60% range for care in pregnancy are Khammam in Andhra Pradesh and West Singhbum in Jharkhand and Nayagarh in Orissa- and the rest fall below 60%. Khammam however has a better utilisation of child care. The lowest figure for care in pregnancy was 42.2% from East Godavari, but this district has 73% of beneficiaries reporting utilisation in sick child care. This pattern is also true for the districts of West Bengal, Kerala, Andhra Pradesh and Angul in Orissa where utilisation in care for the sick child is higher than the utilisation figures for pregnancy care. The lowest figures in the range of 45% for service utilisation in case of a child between six months to two years of age who was sick in last one month were from two districts of Bihar and two districts of Jharkhand.

One caution we need to exercise in interpreting this figure is that even a visit where the ASHAs only contribution was to ask the mother to take the child to the doctor would be counted as a utilisation of her services. Also we cannot from this table, important though it is, form any opinion of the effectiveness of the services so rendered. The most important learning from this finding and perhaps of the whole study, is that even in the best of situations, even for care in pregnancy which is one of the most emphasised aspects of the whole programme, upto 11% of potential users are being missed by the ASHA, and it rises to as much as 58% in East Godavari, 47% in Malda, 45% in Dhanbad, 33% in Nayagarh of Orissa and so on.

The most important learning from this finding and perhaps of the whole study, is that even in the best of situations, even for care in pregnancy which is one of the most emphasised aspects of the whole programme, upto 11% of potential users are being missed by the ASHA, and it rises to as much as 58% in East Godavari, 47% in Malda, 45% in Dhanbad, 33% in Nayagarh of Orissa and so on.

In contrast to care in pregnancy, care of the sick child has not been much emphasised in programme implementation. Yet the figures for utilisation are broadly parallel except for East Godavari in Andhra Pradesh and Malda in West Bengal where there is better utilisation of this service as compared to utilisation for care in pregnancy.

Why then did the ASHA programme fail to reach out to almost one third of the potential service users, even where ASHAs were trained and deployed?

Social barriers and marginalisation are no doubt a reason for poor coverage. We have described earlier that most ASHAs perceive the existence of marginalised groups and many of them report barriers to accessing them. Distance and geographic dispersion of the population she had to cover is the other major determinant of poor coverage.

We looked for statistical associations between perceptions of marginalisation, geographic dispersion and outreach or coverage achieved by the ASHA. In Dhanbad we found that with increasing population coverage a significantly higher proportion of ASHAs were finding difficulty in accessing marginalised households in the coverage area (p value of 0.05). No such association reached statistically significant levels in other districts.

However geographic dispersion was positively associated with intensity of coverage of those whom she does manage to reach. Thus the number of ANC visits she makes was significantly associated with less population to cover in Khammam ($p = 0.001$), Purnea ($p = 0.002$), Jharkhand ($p = 0.006$), Angul ($p = 0.011$) and Banswada (0.002) and Birbhum districts($p = 0.007$). Thus the principle of an ASHA resident in the same habitation is important and even if population covered is high in an area where it implies geographic dispersion than the number of times she is able to make contact with the household at risk comes down significantly. Those who get left out from any contact would also be more where you have high population per ASHA in combination with geographic dispersion. This simply means that we need to insist on one ASHA per habitation where there is much geographic dispersion.

In the absence of her ability to respond to immediate felt health needs of the population (care in illness being the main), her ability to reach out to marginalised sections and facilitate utilisation of services being actively promoted by the government, (immunisation, institutional delivery, spacing contraception etc) is severely compromised

There is no difference between fixed payments (Rajasthan) and performance based payments (Assam) when it comes to ensuring coverage- but non payment and very delayed payment- e.g. East Godavari and Dhanbad could compromise those activities which are part of the payment eligible scheme. Thus coverage decreases if there is very delayed payment. We also tested to see whether the quality of support provided relates to coverage achievement. We find that in many districts the number of visits made by ASHAs to a pregnant woman correlated to her feeling better supported by the ANM or the AWW in Birbhum ($p = 0,017$), Wayanad, (0.015) east Godavari, and Dibrugarh. In most cases it correlates with the support of the ANMs.

Another likely explanation is that in the absence of her ability to respond to immediate felt health needs of the population (care in illness being the main), her ability to reach out to marginalised sections and facilitate utilisation

of services being actively promoted by the government, (immunisation, institutional delivery, spacing contraception etc) is severely compromised, as none of these services are felt needs of these sections. Failure to reach out and provide support or even contact home deliveries for counselling is another indication of how then the priority is being driven from above, the ASHA may fail to reach out to the most marginalised. More active community mobilisation processes should also lead to better coverage.

The failure to reach almost one thirds of the households and the possibility that these may be amongst the most disadvantaged is one of the most important findings of this study- where planned corrective action is essential.

The failure to reach almost one thirds of the households and the possibility that these may be amongst the most disadvantaged is one of the most important findings of this study- where planned corrective action is essential.

There are no easy solutions for such improvement of coverage. Factors that would improve coverage are:

- Smaller populations per ASHA and in all geographically dispersed areas, one ASHA per habitation.
- Position and equip the ASHA as a comprehensive community level care provider, instead of merely a scheme promoter. Skills for responsiveness to felt needs would make ASHAs effective promoters of more appropriate health behaviours. In particular there is a need to continue support to those who are not yet convinced of the need for institutional delivery, immunisation and family planning etc.
- ANM, AWW and ASHA need work as a well knit team, enabling better support and facilitation for the ASHA.
- Sensitising and training ASHA and her facilitators to understand and actively overcome the problem of marginalisation.

Relationship of Skills and System Response to Effectiveness

The ASHA's knowledge and skills are a key determinant of effectiveness. This is supported by statistically significant correlations in those dimensions where other inputs are not needed. The most common relationship therefore is in the relationship to effectiveness of early breast feeding promotion. Pregnant women counselled by ASHAs with higher knowledge levels on this aspect were more effective in Dibrugarh, West Singhbum, and Bundi. (0.001 in -0.042, 0.001). Similar relationship between the ASHAs knowledge and effectiveness on providing advice for ORS and referral for ARI was also seen in Dibrugarh and Khagaria.

We had noted earlier that it was not educational level (8th class pass or not) but the number of days and effectiveness of training that make the critical difference in giving her the necessary knowledge and skills. However for the most part there were so many supply side inputs needed- that ASHAs knowledge and skills and functionality alone would not make a difference in the absence of drugs, referral support from the hospitals and adequate inputs into behaviour change in the community. Besides training programmes have been so few, and with so many gaps and the responses on knowledge and skills are so similar that despite variations and issues on quality of training, it is not the quality of training itself that makes the difference- but what is reinforced in the review and support process.

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In the section below we discuss the effectiveness of the ASHA in relation to a range of tasks. Since there was no baseline data, we have used the District Level Household Survey III (DLHS III) conducted in 2007-2008, as a proxy baseline. The table with key DLHS indicators is in Annexure 4.

I. Care in Pregnancy, Delivery and the Post Partum Period

In Table 19 we present a set of indicators that correlate ASHA's functionality, knowledge and skills to her effectiveness in terms of health outcomes.

If institutional delivery is considered one of the desired outcomes, then we see that of the pregnant women that the ASHA met in their pregnancy, only

Table 19: Task - Care in pregnancy counseling women on all aspects of pregnancy and escort function

	Functionality	Effectiveness			Knowledge	Escort function of ASHA	ASHA
	1	2	3	4	5	6	7
Indicators	% of service users A who were visited at least thrice by ASHA during antenatal period	% of service users A who went for institutional delivery	% of service user A who went for institutional delivery and cited ASHA as a motivator	% of service users A who received three ANCs or more	ASHAs who knew about foul smelling discharge as danger sign to look for.	% of pregnant women line listed who were escorted to the facility	% of service user A who went for institutional delievery and reported that ASHA accompanied
Kerala	**86**	**97.3**	**49.9**	**89.4**	**25**	**7.7**	**9.4**
Trivandrum	85.3	98.3	50.6	89.5	30	8.8	11.1
Wayand	86.8	96.3	49.1	89.3	20	6.7	7.8
Orissa	**72.5**	**92.8**	**94.3**	**70.4**	**36.5**	**58.7**	**83.4**
Nayagarh	60.7	92	95	66.4	51	51.6	84
Angul	83.4	93.7	93.5	74.1	22	65.7	82.8
W. Bengal	**75.1**	**65**	**61.3**	**48.8**	**25.5**	**2.1**	**4.9**
Malda	70.9	58	52.3	56.3	26.8	1.4	4.5
Birbhum	79.8	72.9	69.7	40.5	24.1	3.3	5.3
Assam	**66.9**	**72.3**	**91.4**	**54**	**17.5**	**40.7**	**73.3**
Dibrugarh	87.4	85.4	89.8	79.9	28	46.9	74.7
Karimganj	47	59.3	93.8	28.4	7	33.2	71.3
Rajasthan	**60.8**	**93.5**	**55.8**	**52.2**	**26**	**43.7**	**61.1**
Banswada	60.5	91.7	55	57	29	37.3	52.8
Bundi	61	95.2	56.5	48.1	23	49.1	68
AP	**79.3**	**93.7**	**56.1**	**82.1**	**32.5**	**25**	**53.4**
E. Godavari	76	95.7	68.7	84.8	20	28	69.5
Khammam	83.8	91.1	38.1	78.5	45	18.7	30.4
Bihar	**58.9**	**81.7**	**74.6**	**20.8**	**26**	**54.2**	**91.4**
Khagaria	57.1	79.9	79.8	17.2	37	49.2	86.3
Purnia	60.6	83.4	69.9	24.3	15	59.1	96
Jharkhand	**59.6**	**54.4**	**64.7**	**50.7**	**27.4**	**25.5**	**78.6**
Dhanbad	70.3	51.9	51	57.8	28	20.1	69.7
W.S	50.2	56.7	75.9	44.2	26.8	30.7	85.9

a certain proportion reported that they had an institutional delivery. In Kerala, (Trivandrum and Wayanad), the high level of ASHA's performance in visiting pregnant women is not proof of her effectiveness. Institutional deliveries are over 95% as reported in the DLHS III data, and there is no obvious value addition on account of the ASHA. In Andhra Pradesh we see a similar picture, of existing high levels of institutional delivery and this is likely reflective of better health utilisation patterns. In both these states, about 50% of those who opted for institutional delivery did not state ASHA support as a reason for making this choice, and only about 30 to 35% cited JSY as a reason for institutional delivery. This is likely because the entitlement is limited to women in the BPL category. In Angul, in Orissa, about 60% of deliveries still take place at home according to DLHS III. Therefore when nearly 84% of pregnant women are met by ASHA and of them nearly 94% report institutional deliveries, this increase clearly reflects ASHA effectiveness. This is further validated when 94% of women who sought institutional delivery said they had been referred by the ASHA. In Bihar, 72% of pregnant women were met by ASHAs and 82% of these opted for institutional delivery. However home deliveries account for 75% of all deliveries (as data from the DLHS III, for both Khagaria and Purnea show) and therefore we are concerned that those pregnant women, not met by the ASHA could actually be those who opted for home deliveries. Further, in Bihar, 25% of Service Users A who opted for institutional delivery did not name ASHA as a motivator. The high payment efficiency for JSY to pregnant women in Bihar could have in itself been an important motivating factor for women to access institutional delivery. This trend is also seen in Rajasthan, where 76% of pregnant women were met by the ASHA and 93% opted for institutional delivery, but DLHS III home delivery figures are in the range of 50%. In Rajasthan, 56% of Service Users A who opted for institutional delivery named ASHA as the motivator. A similar pattern is also seen in Nayagarh in Orissa. By contrast, in Jharkhand, though only 60% of pregnant women were met by ASHA, about half of them reported delivering at home. By DLHS III data, home deliveries are nearly 80% in West Singhbum and 65% in Dhanbad. The Jharkhand ASHA is providing as much coverage to home deliveries as she is to institutional deliveries. This is also true of both districts of Assam, but particularly for Karimganj. In Karimganj, 78% of Service Users A reported meeting the ASHA, and 59% reported institutional delivery. The baseline (DLHS III) for Karimganj shows 78% home deliveries, indicating that ASHA are reaching women who have institutional delivery as well as home delivery. 94% of Service Users A in Karimganj who opted for institutional delivery reported ASHA as the prime motivator. Thus in Karimganj, ASHA effectiveness is clearly not due to meeting only those women who would opt for institutional deliveries. Such a pattern is also seen in both district of West Bengal though with low coverage (53%) in Malda The conclusion is that coverage needs to be universal, before we can be sure about effectiveness, namely, that those most at risk, and least likely to opt for institutional delivery on their own are being reached by the ASHA for this task.

The Jharkhand ASHA is providing as much coverage to home deliveries as she is to institutional deliveries. This is also true of both districts of Assam.

The conclusion is that coverage needs to be universal, before we can be sure about effectiveness, namely, that those most at risk, and least likely to opt for institutional delivery on their own are being reached by the ASHA for this task.

The ASHA's escorting pregnant women for institutional delivery is an indicator of functionality rather than effectiveness, especially since the ASHA has not been trained to play a birth companion role. In non high focus states, the need for such an escort function is low, and this is reflected in the data. Data show that in Kerala, West Bengal and Andhra Pradesh, only 8%, 2% and 25% of pregnant women respectively were escorted by ASHA. One reason for this could be that the JSY incentive is only applicable to BPL women. A more

important consideration would be that women may not have even required this service, as there is already a high trend for institutional delivery. Programme managers may not have perceived this as a high priority activity, or linked the incentive closely to this function. Coverage of the escort function, in the high focus states, is modest, ranging from 26% in Jharkhand, 41% in Assam, 44% in Rajasthan, to 59% in Orissa. Functionality in promotion of institution delivery is much higher than the escort role, indicating that the need for both services is very different. However, this should not be a matter of concern since the escort function is perceived by both the beneficiary and the ASHA as a voluntary function to be provided where needed and possible. In states where there is a high escort function that is happening if we require this investment and time to lead to better health outcomes, we should seriously consider training the ASHA to play a birth companion role, as is done in Tamil Nadu.

Escort function is perceived by both the beneficiary and the ASHA as a voluntary function to be provided where needed and possible. In states where there is a high escort function that is happening if we require this investment and time to lead to better health outcomes, we should seriously consider training the ASHA to play a birth companion role, as is done in Tamil Nadu.

The effectiveness of the ASHA with respect to achieving three ANC check- ups, and post partum care and other aspects of pregnancy management, are much lower than the promotion of institutional delivery in all states except in Kerala and Andhra Pradesh. In Kerala and Andhra Pradesh the high performance of ANC check up at 98% and 90% (DLHS III) respectively could account for the high effectiveness of the ASHA in ANC. On ANC check up, there is a significant increase in Orissa and Rajasthan, modest increases in Assam and Jharkhand, uniformly low figure for Bihar, and actual decline in West Bengal. In Orissa, DLHS data is 57% and Service User A data is 70%. In Rajasthan, DLHS III data for the two districts is 26%, and the study data is 52%. In Assam, DLHS III data show 51% against 54% in our study. In Jharkhand, whereas DLHS III average for these two districts is 45%, service user average is 51%. In Bihar, the performance on three ANC check up is particularly poor at 21% by DLHS III and 21% among Service Users A in this study as well. In West Bengal, DLHS III data shows 59% ANC coverage, but the study data indicates only about 49%. Caution must be exercised in interpretation because on indicators such as making an ANC card, TT injection, and for counselling on post partum care and contraception, West Bengal performs reasonably well. In Bihar, by contrast, on all these parameters- the ANC card, the post partum counselling, the counselling on contraception, the functionality and effectiveness is low. The ASHA's knowledge in post partum counselling is low as in West Bengal, but she performs relatively better in contraception. The outcome of the ASHA's counselling in West Bengal on post partum care is likely limited by the low skill level in this area, while the excellent outcomes on contraception relate both to high knowledge levels and possibly easy availability of services.

This comparison between states on functionality and effectiveness is used to make the point that although incentive structures are similar; the ASHA's functionality on a task depends on the support and encouragement for this task. This in turn is reflective of programme perceptions of her as a "commission agent- link worker" or as an "active care provider". Payment could be considered as being indicative of such support, but one could have payment and no such support, or one could have no payment but strong support in the local programme review process. However, effectiveness is a response to the way functionality interacts with the supply side arrangements and the skill levels. A high skill level will not result in better services if the supply side is not in place. (For example, non availability of the ANC card or IFA tablets). However a high skill level and an adequate supply side will not lead to better outcomes if the ASHA is not functional in this area.

II. Care of the Newborn

The pattern shown by the data in Table 20 on newborn care is also instructive. The ASHA in Angul[10], Orissa shows a high level of effectiveness for two outcomes, viz: early initiation of breastfeeding and no pre lacteal feeds. We can see that a high performance on newborn care (85%) has spin off effects in all aspects of ASHA functionality- most dramatically in coverage. (although there is still a last 15% to be reached!!). Newborn care is incentivised in NIPI through a district level newborn care initiative. ASHAs in Angul, also receive a more reliable, more accountable payment and are the best paid ASHAs of all our district case studies. Programme perceptions that community level care is important are reflected in policy support to enable such care. The resultant structures for supervision and regular payment of incentives yield an effectiveness on all areas in which the ASHA is skilled.

We can see that a high performance on newborn care (85%) has spin off effects in all aspects of ASHA functionality- most dramatically in coverage. (although there is still a last 15% to be reached!!).

Table 20: TASK - Newborn care

	Functionality			Effectiveness		Knowledge/skills	
	% of user A who were visited by ASHA on day of birth	% of user A who were visited more than two times in first month after delivery	% of service user A reporting they received advice from ASHA for early initiation of breast feeding	Of user A who were breastfed within four hours of birth	% of user B who gave no pre-lacteal feeds- exclusive breast feeding on first three days	% of ASHA who knew of breast feeding within hour of birth	% of ASHA who knew about exclusive breast feeding from birth
Kerala	**11**	**43.3**	**91**	**92.4**	**96**	**98.5**	**93.5**
Trivandrum	13	53	87.8	94.1	94.9	98	88
Wayanad	9	33.5	94.3	90.8	97	99	99
Orissa	**59.9**	**57.1**	**72.7**	**91.3**	**80.6**	**95**	**83**
Nayagarh	48.7	41.9	73.4	92.8	83.1	95	85
Angul	70.5	71.3	72	89.9	78.5	95	81
W. Bengal	**12.4**	**36.6**	**84.1**	**88.4**	**91.2**	**94**	**90.2**
Malda	12	39.6	75.3	83.5	91.3	93.8	83.5
Birbhum	12.9	33.3	94	94	91.1	94.3	97.7
Assam	**41.1**	**48.8**	**64.3**	**91.8**	**83.5**	**99**	**83.5**
Dibrugarh	27	62.6	71	95.4	88.3	100	78
Karimganj	55	35.2	57.8	88.2	78.9	98	89
Rajasthan	**16.5**	**37.9**	**46.1**	**83.1**	**76.8**	**90**	**82**
Banswada	12.5	32.6	46.9	73.9	70.7	85	84
Bundi	20.1	42.4	45.5	91	82.3	95	80
AP	**46.1**	**57.1**	**79.1**	**90**	**83.3**	**96.5**	**90**
E. Godavari	56.2	59.8	83	97.5	72.5	98	86
Khammam	32.2	53.4	73.9	79.8	95	95	94
Bihar	**47**	**31.6**	**69.6**	**82.2**	**70.2**	**91**	**92**
Khagaria	44.5	30.6	63.9	72.1	61.5	88	89
Purnia	49.4	32.5	74.9	91.6	79.4	94	95
Jharkhand	**40.9**	**37.6**	**82.5**	**74.1**	**73.3**	**93.4**	**84.3**
Dhanbad	37.8	46.8	81.3	75.6	64.6	92	78
W Singhbhum	43.6	29.4	83.7	72.7	81	94.8	90.7

10 Angul is a focus district for the Norway India Programme Initiative (NIPI) which focuses on Home Based Post Partum and Newborn Care.

It is worth noting, that even in Nayagarh district of Orissa, though nowhere near Angul, the performance on many parameters of care in newborn are better- perhaps a reflection of the programme theory and support mechanism in the entire state of Orissa. In most other states newborn visits are still only up to 40% among families who are under ASHA coverage of any sort. Even this level of functionality means a large number of visits – in absolute numbers and this could have resulted in better health outcomes, but then the skills and support are just not in place. This opportunity has not been optimally made use of.

III. Immunisation

A second task for which the ASHA is incentivised is childhood immunisation. Data in Table 21 shows that functionality on the task of attending immunisation sessions is high across all states. However ASHA effectiveness on this task varies. On the indicator of promoting measles immunisation, the outcomes are consistent with the patterns seen in DLHS III especially if one adjusts for the fact that six to nine month olds were also included in the sample. Since figures from

Table 21: Task - Immunisation/VHND sessions

Attending Immunisation Sessions to promote ANC and Immunisation attendance

	Functionality	Effectiveness	Knowledge/skills
Indicators	% of user B who stated that immunisation was facilitated by ASHA	% of service user B – child immunised for measles	% of ASHA who knew Measles vaccines to be given at 9 months
Kerala	**93.8**	**82.7**	**91**
Trivandrum	93.2	89.6	90
Wayanad	94.4	76	92
Orissa	**78.3**	**64.6**	**82**
Nayagarh	86.2	57.9	72
Angul	71.7	70.2	92
W. Bengal	**90.3**	**67.4**	**92.9**
Malda	85.5	74.4	95.9
Birbhum	95.2	60.1	89.7
Assam	**69.5**	**62.6**	**93.5**
Dibrugarh	42	70.7	93
Karimganj	96.4	54.7	94
Rajasthan	**93.9**	**49.6**	**84**
Banswada	92.9	47	75
Bundi	94.8	51.8	93
AP	**78.2**	**32.9**	**81**
East Godavari	75.3	23.6	67
Khammam	81	41.9	95
Bihar	**89.6**	**53.5**	**87.5**
Khagaria	85.1	50.7	84
Purnia	94.3	56.4	91
Jharkhand	**72.5**	**63.6**	**65.5**
Dhanbad	91.2	56.1	80
W. Singhbhum	56.8	69.9	50.5

some states are quite low, in DLHS and in our study, the obvious conclusion is that the high level of functionality and ASHA's knowledge on immunisation promotion does not automatically translate into health outcomes if other supply side factors are a constraint. This has implications both for programme design and viewing immunisation rates as a consequence of supply side issues rather than demand side. (In Andhra Pradesh alone, the data from our study shows far lower coverage than the DLHS III and this needs further exploration).

IV. Care of the Sick Child

In care during illness of the sick child, (Table 22) irrespective of programme theories and support, we find that at least 70% of ASHAs are being consulted. Given that the ASHA is the latest entrant in the field, where a range of other providers including non qualified providers are already in place and providing services for childhood illnesses, this data indicates the level of acceptance that the ASHA enjoys in the community. However despite her being "functional" on this task, her effectiveness is lower. The opportunity to provide appropriate care appears to have been lost in the majority of cases,

Table 22: Task - Common childhood illness and management

	Functionality	Effectiveness	Knowledge/skills			Functionality	Knowledge/skills	
Indicator	Of those user Bs who had diarrhea, the % in whom ASHA helped in some way	user Bs who had diarrhea the % to whom ASHA gave ORS from her kit	% of ASHA had knowledge of making ORS	% of ASHA had knowledge of advising fluid intake in case of diarrhoea	% of ASHA had knowledge of advising continued feeding for the child who had diarrhea	Of those user Bs with signs of ARI, the % in whom ASHA helped in some way	% of ASHAs who could specify chest wall indrawing as a danger sign to suspect pneumonia	% of ASHAs who had drug kit and had cotrimoxazole in their drug kit
Kerala	**92.1**	**82.5**	**79**	**43.5**	**42**	**93.1**	**32**	**8.4**
Trivandrum	86.8	82	73	55	47	86.7	36	15.6
Wayanad	98.1	83	85	32	37	100	28	1.1
Orissa	**90.3**	**82.9**	**64.5**	**53**	**36**	**97**	**69**	**21.1**
Nayagarh	93.4	84.6	62	54	33	94	66	20.2
Angul	89.7	81.7	67	52	39	97.9	72	21.9
W. Bengal	**82**	**51.6**	**44**	**29.9**	**23.9**	**75**	**45.1**	**53.2**
Malda	68	38.6	42.3	30.9	16.5	61	33	39.7
Birbhum	95.7	63.8	45.9	28.7	32.2	80	58.6	69.8
Assam	**70.8**	**54.2**	**74.5**	**14**	**43.5**	**64**	**30**	**5.8**
Dibrugarh	65.2	38	92	21	54	58	29	0
Karimganj	76	69	57	7	33	77	31	11.6
Rajasthan	**66.7**	**56**	**70**	**25.5**	**21.5**	**64.2**	**51.5**	**5.7**
Banswada	65.9	58.5	69	24	14	64.2	50	6
Bundi	67.2	54	71	27	29	64	53	5.5
AP	**85.2**	**71.6**	**45**	**43.5**	**36.5**	**96**	**51**	**17.3**
E. Godavari	84.1	72.7	40	29	17	100	40	24.4
Khammam	86.5	70.3	50	58	56	94	62	10.8
Bihar	**70.9**	**26.7**	**44**	**2.5**	**1.5**	**67**	**44.5**	**NA**
Khagaria	63.3	26.4	10	1	1	62	60	NA
Purnia	90.9	27.3	78	4	2	80	29	NA
Jharkhand	**72.9**	**36.5**	**39**	**21.8**	**29.9**	**67**	**37.1**	**11.6**
Dhanbad	92.3	0	51	20	29	74	65	4.2
WS	69.4	43.1	26.8	23.7	30.9	61	8.2	14.1

due to lack of skills, supplies, or limited support. For example the number of cases of diarrhoea, for whom the ASHA was able to supply ORS from her kit, was 27% in Bihar, 37% in Jharkhand, 56% in Rajasthan, and 54% in Assam. Among the high focus states, Orissa alone did much better with 83% of service users reporting that the ASHA had supplied ORS. It does seem that even where the ASHA was not supplying ORS she was making referrals in the remaining cases, but even then 20% to 35% (Jharkhand) of children with diarrhoea in most states, excluding Kerala did not receive ORS. If we look at knowledge and skills, in addition, we note that the ASHA's knowledge in making home based ORS or in promoting higher fluid intake, or in counselling for continued feeding was uniformly low, with lowest rates being reported from Bihar and Jharkhand. The potential for saving lives through this function which has been one of the main reasons for introducing the ASHA programme, is not being utilised. Uniformly below the block, even amongst department employees, this function of responding to the felt needs of the community and especially the sick child is felt as an urgent necessity. The argument that is being made against any community care role (referred to as the "service provision" role) is more common at higher levels in the implementation chain. It also indicates that ASHAs themselves have shown considerable "agency" in responding to community needs. Better performance in Orissa indicates a better understanding of the community care component at all levels of the system including the leadership.

V. Family Planning

26% of ASHA in Assam, 39% in Bihar, 47% in Jharkhand, 54% in Rajasthan, 71% in Orissa, 73% in West Bengal, and 88% in Kerala and Andhra Pradesh reported providing counselling services for nutrition.

In family planning, the ASHA's effectiveness was limited in IUD insertion and in male sterilisation, though it was reasonable in female sterilisation. Lack of knowledge on family planning as judged by a response on contraceptive advice to be given to a newly married couple was not the limiting factor as this was uniformly high in all states, which ranged from 82% to 98%. (perhaps background knowledge). Functionality in terms of counselling for spacing/family planning during pregnancy was however modest in all high focus states except for Orissa. Possibly this was due to lack of incentives and support for this function. In term of successful referral for service, the emphasis seems to be more on female sterilisation which is largely in keeping with the supply side situation on the field.

VI. Nutrition Counselling

In terms of functionality in the case of nutrition the two indicators used are routine household visits and nutrition counselling as reported by ASHA. Access to anganwadi services also plays a similar function.

Household Visits: The proportion of ASHA that stated making routine HH visits ranged from 57% in Jharkhand to 97% in Kerala. Of the high focus states, 88% ASHAs in Orissa reported making routine HH visits. The figure was less than 70% for the rest of the high focus states.

Nutrition Counselling: 26% of ASHA in Assam, 39% in Bihar, 47% in Jharkhand, 54% in Rajasthan, 71% in Orissa, 73% in West Bengal, and 88% in Kerala and Andhra Pradesh reported providing counselling services for nutrition.

Table 23: Task - Family planning

	Functionality	Effectiveness			Knowledge /skills	
Indicator	% of user A who received advice on contraception during ANC period	Referred atleast 1 case of IUD in last six months	Referred atleast 1 case of female sterilisation in last six months	Referred atleast 1 case of male sterilisation in last six months	Knew the correct contraceptive method of choice for newlywed couple	Knew the correct contraceptive method for a woman who has recently delivered and breastfeeding
Kerala	**61.8**	**58**	**85**	**13**	**98**	**98.5**
Trivandrum	60.8	56	82	5	96	97
Wayanad	62.8	60	88	21	100	100
Orissa	**58**	**28.5**	**64.5**	**2**	**89**	**52**
Nayagarh	58.6	35	46	2	89	54
Angul	57.4	22	83	2	89	50
W. Bengal	**54.3**	**45.6**	**88.5**	**29.8**	**96.2**	**88.6**
Malda	55.6	45.3	87.6	21.7	95.9	89.7
Birbhum	52.6	45.9	89.5	39	96.6	87.4
Assam	**35.5**	**24.5**	**84**	**11**	**90.5**	**67**
Dibrugarh	58.5	12	82	12	95	66
Karimganj	12.8	37	86	10	86	68
Rajasthan	**16.8**	**24**	**77.5**	**7.5**	**87.5**	**82.5**
Banswada	13.9	19	63	7	78	84
Bundi	19.3	29	92	8	97	81
AP	**68.2**	**9**	**84**	**14**	**92**	**91.5**
East Godavari	80.9	14	82	26	95	89
Khammam	51.9	4	86	2	89	94
Bihar	**21.3**	**14.5**	**74**	**3**	**89.5**	**80**
Khagaria	20.8	3	78	4	82	74
Purnia	21.7	26	70	2	97	86
Jharkhand	**45.3**	**27**	**47.7**	**13.7**	**82.3**	**66.5**
Dhanbad	41.5	35	63	6	89	69
W. Singhbhum	48.7	18.6	32	21.7	75.3	63.9

Access to Anganwadi services: On the proportion of children who were regularly using services of the Anganwadi the figures ranged from 84% in Andhra, 75% in Orissa, 69% in Kerala, 68% in West Bengal (48% in Malda and 89% in Birbhum), 62% in Jharkhand, 50% in Rajasthan, 41% in Bihar, and 23% in Assam.

Was the ASHA or even the anganwadi's interventions effective? We have no way of measuring change in malnutrition. We know knowledge on exclusive breastfeeding is over 80% in all states except in Orissa where only 70% of ASHA knew that the baby should be exclusively breastfed for six months. We also have figures which show improvements in breastfeeding.

Knowledge on exclusive breastfeeding is over 80% in all states except in Orissa where only 70% of ASHA knew that the baby should be exclusively breastfed for six months.

Table 24: TASK - House hold visits and nutrition counseling

	Functionality	Effectiveness	Knowledge / skills
Indicators	% of ASHAs who reported regular nutrition counseling	% of user B who started complementary feeding at 6 months	% of ASHAs who knew of fats and oils in complimentary feeding
Kerala	**88.5**	**72**	**37**
Trivandrum	82	71.7	48
Wayanad	95	72.4	26
Orissa	**70.5**	**49.3**	**0.5**
Nayagarh	79	54.5	1
Angul	62	43.1	0
W. Bengal	**72.8**	**38.1**	**7.6**
Malda	70.1	40.5	9.3
Birbhum	75.9	35.7	5.7
Assam	**25.5**	**31.8**	**18**
Dibrugarh	39	29.3	5
Karimganj	12	34.2	31
Rajasthan	**53.5**	**38.3**	**43.5**
Banswada	56	36.2	30
Bundi	51	40.1	57
AP	**87**	**71.3**	**39**
East Godavari	89	69.7	13
Khammam	85	72.9	65
Bihar	**39**	**40.8**	**24**
Khagaria	49	38.5	24
Purnia	29	43.3	24
Jharkhand	**46.7**	**49.3**	**18.8**
Dhanbad	51	49.1	23
W Singhbhum	42.3	49.5	14.4

But there are so many crucial elements of knowledge on nutrition counselling missing in the ASHA's training, that we cannot have too much of an expectation on change in other areas of malnutrition prevention on management. For example, on the issue of adding fats and oils for complementary feeding, the knowledge levels were very low, ranging from 1% in Orissa to 44% in Rajasthan. The higher data in Rajasthan is accounted for by the fact that the ASHA were part of the ICDS system, and probably had been trained with more rigour on nutrition topics. Even on the proportion of children who were given complementary feeds at six months of age- the figures are low in most states, except for Kerala and Andhra Pradesh with about 72%. Clearly this is an area where despite the window of opportunity provided by the ASHAs functionality on household visits, the programme has not taken off due to weak training and support.

VII. TB and Malaria

ASHAs do play a role in both TB and Malaria as seen in Table 25. In the case of TB, functionality among the ASHA is high when considering the number of TB patients she reports. 71% of ASHA in Andhra Pradesh, 64% in Bihar,

Table 25: Task - Malaria and TB

	Functionality		Drug kit support	Knowledge/skills		
Indicator	% of ASHAs who reported doing any malaria related work	% of ASHAs who reported TB cases in their area and are acting as DOTs provider	% of ASHAs who had a drug kit on the day of interview and had chloroquine in their drug kit	% of who knew of sputum collection in chronic cough	% of ASHAs who knew that drug to be given in suspected malaria	% of ASHAs who knew that blood slides had to be made in case of symptoms with fever and chills
Kerala	**58.5**	**77**	**6.8**	**99**	**86.5**	**71.5**
Trivandrum	62	74	12.5	100	86	77
Wayanad	55	80	1.1	98	87	66
Orissa	**80**	**95**	**21.1**	**91**	**22.5**	**90.5**
Nayagarh	76	93	24.5	92	32	96
Angul	84	98	17.7	90	13	85
W. Bengal	**51.6**	**83**	**22**	**93.5**	**30.4**	**77.7**
Malda	54.6	76	20.5	94.8	33	80.4
Birbhum	48.3	93	23.8	92	27.6	74.7
Assam	**20.5**	**87**	**23.3**	**90**	**66**	**96**
Dibrugarh	21	95	2.1	85	88	99
Karimganj	20	82	44.2	95	44	93
Rajasthan	**31.5**	**68**	**7.3**	**72**	**74**	**76**
Banswada	23	64	10	73	61	68
Bundi	40	72	5.5	71	87	84
AP	**66.5**	**90**	**21.8**	**89**	**43**	**97**
East Godavari	64	84	20.9	87	22	94
Khammam	69	98	22.6	91	64	100
Bihar	**17**	**79**	**NA**	**81**	**1**	**72**
Khagaria	21	71	NA	78	1	63
Purnia	13	87	NA	84	1	81
Jharkhand	**30.5**	**84**	**32.6**	**73.1**	**26.4**	**86.3**
Dhanbad	22	90	12.5	80	6	89
W Singhbhum	39.2	80	39.4	66	47.4	83.5

62% in Orissa, 55% in West Bengal, 52% in Rajasthan, with 50% in the remaining states reported that they knew of TB cases in their area. Of these 90% of ASHA in Andhra Pradesh, 79% in Bihar, 95% in Orissa, 83% in West Bengal, 68% in Rajasthan, 84% in Jharkhand, 87% in Assam, and 77% in Kerala reported providing DOTS treatment. Given the overall prevalence of TB of 0.25 per 1000 the ASHAs functionality and effectiveness on this can be considered to be adequate.

In the case of Malaria, functionality as reported by ASHA was modest except in Orissa and Andhra Pradesh, with less than half of the ASHAs reporting functionality. Knowledge levels on knowing that a blood smear needs to be made to diagnose malaria was good with over 85% of ASHA in Orissa, Assam, Andhra Pradesh and Jharkhand responding positively. However on knowledge of the drug of choice for malaria, the figure was 87% in Kerala, 66% in Assam, 74% in Rajasthan. In the rest of the states – many of which are malaria- endemic states including Orissa, fewer than 45% of ASHA were able to state this correctly. This again means that in some states the good

Knowledge levels on knowing that a blood smear needs to be made to diagnose malaria was good with over 85% of ASHA in Orissa, Assam, Andhra Pradesh and Jharkhand responding positively.

level of functionality would not lead to effectiveness in prompt treatment for malaria, and in some states- she was neither adequately functional nor effective.

Discussion

We conclude that the ASHA's functionality and potential functionality is well established by this study, but to make her more effective in terms of leading to health outcomes, the training design has to include a better designed skill package, and the support systems must be improved and there must be a planned effort made to address issues of marginalisation.

One of the most frequently asked questions is the impact of the ASHA programme on health outcomes. We have tried to address this question in this chapter. First we begin by recognising that one of problems of impact evaluation of the ASHA programme is attribution. When there are so many schemes, closely related to each other, which have been rolled out for maternal and child survival, how do we attribute a change to only the ASHA programme? Second there are no control areas possible or available against which changes can be compared and there are problems about getting baseline data for the sampled areas. Finally even measuring changes in health status is a problem.

We have therefore studied changes in health practices or behaviours, changes in utilisation of services, and appropriate care provision or response to illnesses as the nearest indicators of health outcomes which we could study. We find that there is substantial improvement in these outcomes, but much less then what would be expected from the high figures of ASHA functionality. Limitations in coverage, lack of skills and systems support reduce the potential effectiveness of this programme, and this is unfortunate, for the ASHA is willing and putting in the efforts, but due to a strong perception amongst many implementers that she should be limited to only acting as a facilitator/commission agent or link worker, we are losing the opportunity for making a much larger health impact.

We conclude that the ASHA's functionality and potential functionality is well established by this study, but to make her more effective in terms of leading to health outcomes, the training design has to include a better designed skill package, and the support systems must be improved and there must be a planned effort made to address issues of marginalisation.

CHAPTER 6

Discussion – the Context-Mechanism-Outcome Configuration and Its Interpretation

The whole point of this approach has been to show that there will always be differences in opinion about "how the ASHA programme works". Providing that this question is posed in a properly circumscribed way, then it is possible to furnish grounds for why one account can be preferred. A Context Mechanism Outcome (CMO) configuration is a proposition stating what it is about a program which works for whom in what circumstances. The conjectured CMO configuration is the starting point for an evaluation. And the refined CMO configuration is the finding of an evaluation.

We examine the CMO configuration in each of the states and try to define what has worked well in the specific state context and with that particular choice of mechanisms. Based on this analysis and by comparison to other states we make recommendations specific to the state. These are over and above the general recommendations which apply to all states and which we state at the end of this chapter.

The order of states we choose is the gradient of performance based on the ASHAs outreach to her key service users – pregnant woman and mothers with a sick child. Kerala heads the list, followed by Orissa, West Bengal, Assam, Rajasthan, Andhra Pradesh, Bihar and Jharkhand in that order.

The whole point of this approach has been to show that there will always be differences in opinion about "how the ASHA programme works". Providing that this question is posed in a properly circumscribed way, then it is possible to furnish grounds for why one account can be preferred.

I. Kerala

Kerala is renowned for its good performance in both health status and health services delivery. Kerala is doing very well in its RCH indices as well as the delivery and utilisation of RCH services. With an IMR of 12 and an MMR of 95, and institutional delivery rate of 98%, immunisation rate of over 90% and even appropriate care seeking for pneumonia, diarrhoea etc., it was difficult to justify the ASHA programme by RCH goals. Kerala gave up its "second ANM" provision under NRHM for the ASHA programme at a time when it was not yet sanctioned for the state. It politically argued that ASHA was needed, not so much to promote RCH services, as to expand to comprehensive care especially the rising burden of non communicable diseases.

Most implementers believed that the ASHA programme would deliver by facilitating people to attend facilities-that too for RCH services and to some extent for screening and management of NCD. Training had been good and covered these topics. Selection had been through a formal process, but with little

mobilisation and no perception of activism or reaching to marginalised sections. There was a strong view amongst programme managers that marginalisation was not a significant problem. There was no full time support structure at any level except a rather weak state level resource team. However it is worth noting that the JPHN is much more available for supervision than in any other state- for her work on immunisation, midwifery and even antenatal and post natal care has shifted to PHCs and higher facilities and her work on home visits has shifted to the ASHA whose supervisor she has, in effect, become.

This strong political support for ASHA and the initial rationale for their deployment in NCD programmes does not translate into a technically viable approach with measurable outcomes.

The study showed that in terms of health outcomes the programme does very well. Thus 99% of babies are weighed on the first day of birth, 92% breastfed within the first four hours of birth, 72% started weaning foods on time, 87% received ORS for diarrhoea and 97% sought treatment for signs of suspected pneumonia. This is not surprising for there was a much better base-line here and the problems of social barriers are much less. The good performance on health outputs, on almost every indicator clearly reflects the state context of high availability, accessibility and use of public health services. We however note that about 15% of the potential beneficiaries, did not meet the ASHA, and one has to be concerned that this 15% does not belong to the socially excluded. Despite this access to ASHAs is the highest across the 8 states for both the pregnant women and the sick child and for attending immunisation day. In terms of services accompanying for delivery, counselling on post partum care or contraception, and visiting the newborn in the post – partum period, the figures were modest. Even on knowledge and skills, they were similar to most states.

The key question is – is there any value addition at all, or is the ASHA only reinforcing and supporting what would have happened anyway? In focus group discussions with peripheral health workers, they were at a clear loss to explain this. At senior levels there was an insistence, that there has been a decline in RCH service delivery and therefore the ASHA was needed. It was pointed out that the entire decline is from a few blocks and would not justify a state-wide ASHA programme.

This strong political support for ASHA and the initial rationale for their deployment in NCD programmes does not translate into a technically viable approach with measurable outcomes. Part of the reason was the delay in launching the non-communicable disease programme. The programme design is also incomplete in terms of indicators and strategies proposed. The other reasons are that the ASHA's role is limited to bringing the potential patients for screening and follow up to the infrequent NCD camps at the PHC. This means that her contribution is limited by the number of camps that can be organised – which are vey few indeed. At present in a good programme, only about 10% of the population to be reached gets covered. If on the other hand the ASHA is taught to take BP and test the urine for sugar coverage could rise to 100% but there the system becomes very reluctant to equip the ASHAs with such skills. We note that the basic educational level of the ASHA is much higher than all other states and she could easily learn this skill but the problem is the same as we face for newborn care, i.e., that the professional boundaries that cannot be transgressed.

If on the other hand the ASHA is taught to take BP and test the urine for sugar coverage could rise to 100% but there the system becomes very reluctant to equip the ASHAs with such skills.

There is an interesting palliative care programme that has been rolled out in Kerala. Palliative care consists of identifying all those in the community who are

bed ridden and unable to take care of themselves either due to chronic disease, or due to disability or due to mental health issues or most commonly due to old age and then organise visiting them and assisting them. There is a conscious decision to limit the ASHA's incentives to RCH activities and not incentivise palliative care, because this work is valued highly and therefore needs to be kept voluntary. However officials also note that there is an increasing call to incentivise it.

The Way Forward

We agree that RCH is an unfinished task, with danger of slipping back, but to address this, there must be a study of who is getting left out and a conscious effort to identify and address marginalisation. ASHAs, her supervisors and managers must be sensitised on this. A state wide approach to addressing the last mile in RCH is not the best way forward a focussed approach would yield better outcomes.

We agree that RCH is an unfinished task, with danger of slipping back, but to address this, there must be a study of who is getting left out and a conscious effort to identify and address marginalisation.

a) The ASHA should be more than an extension worker of the department, assistant to the ANM and to the Panchayat. She should play an important part in the VHSC and health planning. Though in other states, the problem is much less, in Kerala the ANMs work especially in non communicable diseases needs to be defined.

b) A menu of activities for non communicable disease and palliative care should be worked out for the ASHA. This should be part of a State wide NCD programme with measurable outcomes for all, including the ASHAs. Hard skills that the ASHA needs to be effective should be provided to her if the investment in such a workforce is to be justified. Today the value addition she brings does not justify it. The NCD programme should aim for universal coverage.

c) Malnutrition and anaemia is still a problem. Anaemia too is a non communicable disease. Testing for anaemia, and treating, until re-testing shows anaemia correction could be made a major part of the programme. There is very little of the activist or rights orientation. There is no conscious identification or planning for reaching those sections which are getting left out. There is also little expected in the way of measurable outcomes expected and therefore not much need felt for on the job support, or even a more rigorous training.

A menu of activities for non communicable disease and palliative care should be worked out for the ASHA. This should be part of a State wide NCD programme with measurable outcomes for all, including the ASHAs.

d) Addressing health seeking behaviours which leads to irrational and high consumption of care like C sections in 70% of pregnancies should be addressed by building awareness on these issues. This role as a care provider that has emerged, due to her own agency more than anything else, should be used to reduce costs of care for common illness of children without reducing prompt referral as the first option for serious signs but even for this she would need much higher skills and support.

e) Linkage with the RSBY programme is proposed. There is an immense role of gate-keeping that is needed to ensure that the usual moral hazards of a health insurance programme do not adversely affect the interests of the poor. ASHAs could act as RSBY agents and at the same time play a supportive and facilitatory role for this programme.

II. Orissa

Orissa is one of the most challenged states in terms of RCH indicators. It has an IMR of 65 – the second highest in the nation and a MMR of 303. The good news is that in 2009 its birth rate has reached replacement levels but this lends even greater urgency to the task of accelerating child survival. Orissa is also a high malaria state and the IMR which is out of proportion to its much better performance on many child parameters like immunisation has been attributed to this. Orissa is also a largely tribal state and in all but 6 coastal districts and some of the western and southern districts, is also challenged by very poor base lines of health service delivery.

Orissa has clearly done the best among the eight states on many parameters.

Fortunately Orissa has had political stability in this period combined with political will to make a visible impact on health and ASHA has been a priority. The understanding of how the ASHA programme works from the leadership down to every level of implementation is also aligned to a good public health understanding of how community care impacts on child survival what we called the framework of understanding–2. This has led to seriousness in putting in place a support structure and maintaining a good pace of training. Selection processes have been thoughtfully and pragmatically innovated and have yielded the desired outputs. Payments are performance based, but mechanisms are thought through and amounts received are significant. Incentivising home based newborn care has been a big step forward.

All this has resulted in the second best outcomes amongst the states studied. If we factor in the rise in performance over the baseline (as measured by DLHS-III) Orissa has clearly done the best among the eight states on many parameters for Kerala, unlike Orissa already had very good baselines.

There is however a significant difference between the two districts - Angul and Nayagarh. ASHA did not reach 33% of pregnant women in Nayagarh as compared to only 15% in Angul. Of those whom ASHA reached about the same percentage chose to go for institutional delivery (94% and 92%), and ASHA accompanied 84% in Nayagarh and in 83% in Angul. The difference between the two districts is thus attributable almost entirely to outreach.

When it comes to visiting the newborn on the first day, only 49% have done so in Nayagarh as against 71% in Angul and for making more than two post partum visits, the figure in Nayagarh is 42% and 71% in Angul. In Angul, not only have ASHAs been trained for six days for this, they have also been incentivised for newborn visits and are receiving Rs. 250 per newborn for a set of three visits. In many other parameters of sick child care such as management of diarrhoea and management of pneumonia, the performance in both districts is very similar; keeping in mind that in Nayagarh only 62% of sick children accessed services as against 88% in Angul. Knowledge and skills are not the big difference either across the two districts; which is a surprising finding.

In Angul, not only have ASHAs been trained for six days for this, they have also been incentivised for newborn visits and are receiving Rs. 250 per newborn for a set of three visits.

One explanation that could fit is that the payments are more substantial in Angul and newborn care is also incentivised 82% of ASHAs earned over Rs. 1000 per month, in comparison to only 45% in Nayagarh. 40% in Angul got over Rs. 1600 per month!! This is the highest reported from any area so far. But is this cause or effect? In both districts, ASHAs get paid about the same amount for JSY (Rs. 200 or Rs. 350 per case plus transport), attending immunisation sessions (Rs. 150 per month) and attending meetings

(Rs. 150 per month). So it is unlikely that payment alone accounts for higher coverage in Angul for care in pregnancy and for the better performance in institutional delivery. The pattern in population covered and number of households per ASHA is about the same in the two districts. The number of households to be covered, and the time taken to reach the most distant hamlets is about the same. Cycling is the most common way of reaching these hamlets in both districts. Exactly 97% of ASHAs in both districts recognise marginalised sections as being present in their areas, and 30% in Nayagarh and 33% in Angul report social barriers to access. Dropout rates, and times spent on daily work are similar, though it is a bit higher in Angul. The percentage of ASHAs who attended the immunisation sessions regularly in the last three months is 90% and this is particularly robust data for we are triangulating with what ANMs and AWWs working in these areas are saying and it is over 95% in both these districts. This is reflective of similar levels of motivation and functionality in both districts. Community Mobilisation could be a possible explanation between the two districts but the data does not show much difference in activities related to mobilisation however defined between the two activities.

It seems likely that the addition of newborn care has had spin off effects into enlarging the number of potential users reached for all aspects of health care that the ASHA provides. Angul is also one of the best of the NIPI projects which is focussed on child health and which has rolled out a home based newborn care programme in Angul which has not only improved newborn care- but also increased coverage of all other services. The excellent performance in Angul as compared to Nayagarh has also some contextual factors. Angul is a more central plains districts with much higher level of development.

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Looking at family planning we see that in all parameters of family planning, but especially successful referral for sterilisation, Nayagarh is doing much less than Angul on female sterilisation but more on IUD. This did not relate to knowledge or skills which were about the same in both districts, but it is very likely to be due to supply side factors.

In Malaria and TB control, there is not much difference, with very low performance in both districts. Awareness is low-but lower still is the availability of chloroquine in the drug kit. Here clearly there is a picture of system responsiveness and support being the critical limitation in making ASHA effective, even to the extent she is functional. This is a tragic opportunity lost for Nayagarh where malaria is a terrible scourge and even for Angul. Clearly many lives that could have been saved by chloroquine may not have got that chance.

The Way Forward

a) Need to strengthen substantial knowledge and skill gaps in the area of nutrition, community level care for illness in the young child, care for the newborn and malaria. The ASHA is already active in this area, and well supported, but the training programme has been weak. It is not the delivery of training that has been the central problem but the inadequacy of the content and design itself. All these topics are covered, but inadequately. The high ASHA functionality is a great opportunity to save lives, but it would be undermined by the lack of skills.

b) Strengthen the ability of facilities to manage increased referrals.

c) In malaria even the delivery of training has been weak and the programme would need to be strengthened.

d) Sensitisation to the need for social mobilisation and the need to address marginalisation would be useful.

e) Need to strengthen the VHSC and its functioning and link up the ASHA more substantially into its functioning.

f) There is a need to create a cadre of ASHA facilitator at this stage best done by promoting one of the 20 ASHAs in that area and train her appropriately.

g) Build up a long term plan for those ASHAs who are interested to access ANM and nurse training.

h) Widely disseminate the learning from the excellent selection, payment and review mechanisms in place in Orissa.

III. West Bengal

The final performance on many indicators seems to be more reflective of the baseline in service delivery. Birbhum does much better with ASHAs reaching 86% of pregnant women and 91% of sick children. In Malda the corresponding figures are 53% and 74% respectively.

West Bengal has a relatively good record in IMR (33) and MMR (141) and in immunisation levels. But in many aspects of service delivery, especially those relating to facility based services like in institutional delivery its record is much poorer. West Bengal has a strong Panchayat system and a stable, supportive administrative and political leadership.

With respect to the ASHA programme, West Bengal has been very risk averse and has chosen to roll out the programme very slowly, even if it means loss of funds only half the state is covered as of today. It is also risk averse in putting in place such rigid and mechanical rules for selection with formal advertisements, applications and an recruitment committee. This made the selection demonstrably fair, but it ruled out all opportunity for social mobilisation. Payments in Bengal are on the ground a more or less steady amount of Rs. 800 per month.

The training programme was of good quality with a substantial step-up of content and strategy by the implementing NGO. This also introduced its own facilitator module and emphasised skills in some areas.

However given the much better baselines in service delivery, it is not very clear whether ASHA programme has provided much improvement over the baselines. The final performance on many indicators seems to be more reflective of the baseline in service delivery. We consider this possibility after examining the significant difference between the two districts. Birbhum does much better with ASHAs reaching 86% of pregnant women and 91% of sick children. In Malda the corresponding figures are 53% and 74% respectively. The level of knowledge of skills as regard pregnancy in the two districts was almost the same. But effectiveness in terms of receiving three ANCs was 56% in Malda and 41% in Birbhum, while making an ANC card was 60% in Malda and 78% in Birbhum, Measles coverage was 74% in Malda and 60% in Birbhum, 87% of children with Diarrhoea in Birbhum have received ORS and of this 64% had received it from ASHA whereas in Malda 64% of children with Diarrhoea were treated with ORS and of this 39% from ASHA. The percentages of pregnant women who are counselled on post partum care, contraceptive or the five cleans were almost the same in both districts. We could conclude therefore, that the

level of knowledge, skills, functionality and programme support was about the same in both districts, and both outreach and effectiveness depended upon the context and the system responsiveness. For example it is worth noting that on the date of the interview, 91% ASHAs in Birbhum had ORS on their kit while only 26% of ASHAs in Malda had ORS on theirs. However, the percentage of ASHAs who could describe adequately how to prepare home base solutions or advise on continuing feeding children in case of diarrhoea or even increase food in take in general were deplorably low in both districts.

Community Mobilisation was weak in West Bengal in both districts with very few reporting functional VHSC or taking any mobilisational efforts to ensure access to AWW or ANM services or making special efforts to reach out to marginalised sections.

One important difference between the West Bengal programme and all other states studied is the high degree of focus on promoting contraception and the high degree of effectiveness with which this task is accomplished. This is not driven by incentives, any more than JSY is. Obviously what an ASHA is encouraged to do, what she is supported to do and what the system is able to respond to, defines outcomes far more than what they are paid for. Payment itself may only be acting as the most important form of such encouragement and focus.

One important difference between the West Bengal programme and all other states studied is the high degree of focus on promoting contraception and the high degree of effectiveness with which this task is accomplished.

We find a curious disjunction between programme theory at the higher level and programme practice on the field. At the state level the programme ASHA is described as a link worker, limited to facilitatory roles and paid a performance based wage for purely facilitator functions. On the ground we find ASHA much more as a community level illness care provider with more drugs than in any of the other states, who is paid on a fixed basis, whose facilitation function for immunisation and family planning is good, but for institutional delivery is very low one of the lowest anywhere in India for the escort function, with no activist or mobilisational dimension. The high functionality of ASHAs does not however translate into effectiveness due to lack of service delivery at the facility level. It is not clear from the functionality-effectiveness tables as to whether the ASHA programme leads to any value addition in RCH, or merely.

On the ground we find ASHA much more as a community level illness care provider with more drugs than in any of the other states, who is paid on a fixed basis, whose facilitation function for immunisation and family planning is good, but for institutional delivery is very low one of the lowest anywhere in India for the escort function, with no activist or mobilisational dimension.

Birbhum possibly does better because of the availability of drugs and greater responsiveness to minor illness in the community. Overall although West Bengal is one of the better programmes, compared to the other states in terms of health outputs one can see that due to the lack of any supervisory structure, the loss of linkage between performance and payment and because of poor facility response and support, the outcomes are much less than it could have yielded.

The Way Forward

a) Expand the programme to the whole state at a faster pace. The main reason for the slow expansion is the reluctance to expand management capacity either by bringing in more NGOs like CINI or creating a fully staffed ASHA resource centre. This must be corrected.

b) This lack of management capacity is affecting the pace of training and the quality of support, even where the programme is already reached.

The lack of management capacity at the district level and the lack of facilitators/trainers at block level prevents better training and support. This should be corrected at the earliest.

c) The system must recognise what tasks the ASHA is functional on, and how closely they relate to the health priorities as is known from public health literature. Though West Bengal has the third lowest IMR, it is 8th in under 5 MR and diarrhoea and ARI is the main killer in this age group. Training programmes must strengthen the ASHA's capacity to manage these illnesses and to provide newborn care by providing her with more skills.

d) Currently the ASHA is supporting existing health seeking behaviour, but has not made much headway in reaching out to new sections which are not utilising these services. More effectiveness on responding to peoples felt health needs would help her reach out to these sections.

e) There is a need to increase the level of social mobilisation and efforts to identify and reach out to marginalised sections.

f) Facility based services that manage referrals must improve if the increased activity of ASHAs at community level care is to yield results. The expansion of institutional care for sick newborns and children is at too slow a rate for a programme that depends so much on referral.

g) There is a need to strengthen measurement of outcomes and use review of this to improve the programme. This is all the more essential if the system would be based on a fixed payment. A regular mechanism of review based on key indicators developed for the programme is an urgent necessity.

h) The state should consider cutting back on fixed payment and increase the performance based component which is focussed to address key changes required.

IV. Assam

The ASHA programme however has enjoyed a high political support, and an enviable continuity in administrative and political leadership. The programme has put in place a good management support system and trainers at the sub-block, block, district and state level.

Assam is the largest state and one of the states which have the poorest performance in RCH. Its MMR at 480 is the highest in India and its IMR in 61 is one of the highest. Population stabilisation also is some distance away, though there is consistent improvement. Assam has problems of geographic and social barriers to health care access. Its health care systems and baselines in health care delivery are also much worse than the national average and bring it into the high focus group.

The ASHA programme however has enjoyed a high political support, and an enviable continuity in administrative and political leadership. The programme has put in place a good management support system and trainers at the sub-block, block, district and state level. The training programme has been rolled out but going by the scores on knowledge and skills, the training outcomes are modest. There have also been no efforts to improve upon the central modules as many other states have done. Drug kits are provided, but refills were poor. Payment is strictly performance based, but very well organised and most ASHAs do earn significant amounts and collect it with relative ease.

District divergences in performance in Assam are much less than for Orissa and West Bengal. Taken together the ASHA reach 77% of pregnant women and 67% of sick children. Out of the 77%, 72% opted for institutional delivery but the distribution appears skewed with 85% in Dibrugarh and 59% in Karimganj. Thus of all pregnant women 47% in Dibrugarh and 33% in Karimganj were accompanied by ASHA for delivery. One reason for the poor conversion to institutional delivery may be the lower number of Ante natal visits the pregnant women received in Karimganj from the ASHA (three visits - 47%) whereas the corresponding figure in Dibrugarh was 87% for the ASHA. The content of counselling in Karimganj was also much weaker: only 13% on contraception, 2% on the five cleans, 11% on post-partum care; however 89% of the mothers had received TT Injection.

In child care, in terms of regularity of immunisation, ASHA is as good as in any other state-about 90% attendance but as in the case of three ante-natal visits, the children immunised for measles 55% in Karimganj as against 71% in Dibrugarh. In terms of newborn visits on the first day, more than two post partum visits and presence during weighing, about 50% of ASHA had been active in both districts even though this is not a state where newborn visits have been insisted on or incentivised. Some changes like early and exclusive breastfeeding were largely achieved though others like weaning in time was happening only in 32% in children. Though 83% of ASHAs knew about weaning, these aspects of the programme were neither monitored or supported.

Similarly where the ASHA reached children with diarrhoea she gave ORS in 69% cases in Karimganj and only 38% in Dibrugarh. This correlates with the findings that 44% of ASHA in Karimganj had ORS packets to give whereas only 1% of ASHAs in Dibrugarh had a packet. It is worth noting that the drug kit in Dibrugarh was empty, not only of curative drugs but also IFA and paracetamol. ASHAs in Dibrugarh were more skilled and able to give counselling for home based measures. On the whole much could be done to improve the skill level. Performance of ASHAs in family planning is very low in both districts and so too on Malaria and TB activity levels of ASHA are about 20% and 11% respectively from both the districts.

In terms of community mobilisation the VHSCs are much more functional and in all of them ASHAs are an active participant and they feel supported by the structure. The majority of ASHAs also reported being active in community mobilisational roles particularly water and sanitation activities and services entitlement.

The senior leadership considered ASHA as being effective only through her facility utilisation role-and the incentives and monitoring are focussed on this. Training has also been focussed on this-and therefore though promotion of institutional delivery and immunisation occurs, associated counselling for health behaviour changes and the changes themselves are weak. Functionaries at the block level have been more pragmatic possibly considering the level of facility level care available. There is responsiveness to common illness, though the level of skills with which it has been managed are insufficient even to recognise conditions requiring referral and support in the form of drugs. Despite this limitation it is important to note that for most illnesses and for newborn care she is already emerging as care provider of the first resort.

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The Way Forward

a) The management structure is in place but it urgently needs skill building to improve its functioning.

b) The ASHAs are functional in all the important tasks as envisaged in the national guidelines, but their support and drugs supply and system responsiveness in terms of service delivery is insufficient to be effective on many of these functions.

c) The training programme should be strengthened and made skill based; ASHAs should have a clear idea of what measurable outcomes they can bring about.

d) Much greater attention is needed for the family planning and nutrition components as well.

e) There should be a system of review, using an indicator which helps us know which areas of work she is functional on, and needs more support to become effective.

f) There should be a greater sensitisation and importance given to recognising and responding to marginalisation. The fact that a substantial part of the population is getting left out should be brought to notice and addressed.

V. Rajasthan

Rajasthan is a large state with poor health indicators. It has an MMR of 388 and an IMR of 59. The programme differs from that in other states in that an existing cadre of health workers called Sahayogini who were being paid Rs. 500 per month and assisting the Anganwadi worker through an administrative order converted into ASHAs. A sum of Rs. 450 was added on. This sum of Rs. 950 was in addition to performance based payments. They had an initial training of ten days with the ICDS department. This was followed by an seven days on Module 1 and then another 4 days where all the remaining three modules were completed.

The state also developed a support structure with a district level community mobiliser a block coordinator and one contractual support person for every sector. A rudimentary resource centre came up at the state centre, but never stabilised. Training pace, despite these structures, was very slow. An IMNCI module was proposed and rolled out in part of the state. The payment of Rs. 500 was regular, but of the Rs. 450 was irregular. The performance based payments were also irregular and did not incentivise ASHA support to the JSY, to the same extent as it did in other states. This could have been because she had to compete for the incentive with AWWs and dais and therefore got it less often.

The picture in Rajasthan seems similar to the scenario described for Assam with ASHA reaching to 76% of pregnant women and 67% in sick children. Largely those pregnant women who were visited by ASHA have opted for institutional delivery even though ASHA needed to accompany then in only half of the cases. On the other hand three ANC visits remain low at 50% and counselling on many key aspects of pregnancy care and contraception remained very low despite the ASHA visits. The impression is that the focus was so completely on promotion of institutional delivery that all other dimensions of care lost out. In

newborn care, visits to the newborn and postpartum care are significantly less than in Assam though thanks to the much better linkage with the ICDS system baby weighing at birth is much better. Her functionality and effectiveness in nutrition especially breastfeeding and complementary feeding is however very poor. As compared to Assam, she has been better in securing Anganwadi services but despite the strong ICDS linkage this result is less than many other states. Again though attendance at immunisation is in the 90% range, measles immunisation is only 50%. Of the 207 children who had diarrhoea 67% reported that ASHA has assisted them in seeking care and 56% received ORS from ASHA. Non ORS dimensions of diarrhoea management were poor and about 70% could state correctly the steps in making home based ORS. Whereas about 86% of children had ARI only 50% of ASHAs could state how to recognise pneumonia though 64% of children who had such symptoms had sought the ASHAs help. On the day of the interview less than 10% of ASHAs had any drugs in their kit. As in Assam, functionality and effectiveness in family planning is low. Community Mobilisation was weak except for ensuring water and sanitation facilities where about 50% of ASHAs were active.

Programme appears to be institutionally focussed on facilitation for JSY and Immunisation. It has better linkages with the ICDS programme and this has provided more newborn care but has not otherwise translated into better child health and nutrition.

In conclusion, the Rajasthan programme appears to be institutionally focussed on facilitation for JSY and immunisation. It has better linkages with the ICDS programme and this has provided more newborn care but has not otherwise translated into better child health and nutrition. ASHAs are functional in responding to illness but there are no drugs in their kits and the skills needed for non drug interventions in these illnesses are inadequate. In the dimension of pregnancy care other than institutional delivery, family planning and newborn care, though the ASHA provides the opportunity for interventions the skills and supervisory support have to be built up.

The Way Forward

a) The management structure is in place but it urgently needs skill building and strengthening to improve its functioning. The resource centre should be developed under an able leadership or outsourced to a suitable organisation.

b) There should be a greater sensitisation and importance given to recognising and responding to marginalisation.

c) There should be a system of review, using indicators which help us know which areas of work the ASHA is functional on, and needs more support to become effective.

In the dimension of pregnancy care other than institutional delivery, family planning and newborn care, though the ASHA provide the opportunity for interventions the skills and supervisory support have to be built up.

d) The ASHAs are functional in all the important tasks as envisaged in the national guidelines. The ASHA programme in Rajasthan is too focussed on the twin tasks of immunisation day attendance and institutional delivery promotion that even associated health behaviours are not addressed adequately.

e) The training programme should be strengthened and made skill based; ASHAs should have a clear idea of what measurable outcomes they can bring about. They should be supported with drug kits and supervised to achieve the key goals of the programme.

f) Where suitable literate ASHAs are not found within the hamlet, one must relax the educational criteria to get a suitable woman and then invest more in training her.

g) All the points made in the general recommendations are particularly relevant to Rajasthan where the programme is performing below expectations.

VI. Andhra Pradesh

Andhra Pradesh is one of the good performing states. Its TFR is well below replacement levels, its MMR is at 154 and its IMR is at 49 – low for the more developed states, but still better than the national average. There are however many districts where development is limited and health services are very weak.

In terms of illness care however the ASHA are much more active and over 85% children with diarrhoea had received assistance from ASHA and 72% had received ORS.

Andhra Pradesh presents an interesting pattern where there is much greater coverage for care of the sick child and much less focus on the pregnant women. The main problem here is in reaching out to all the women and it appears that this reaching out is preferentially to those who are likely to go for institutional delivery. So though only 42% of pregnant women in East Godavari have been reached, 96% of those reached opted for institutional delivery and 70% were accompanied. But on the whole of all pregnant women only 28% had ASHA playing an escort role. In Khammam the corresponding figure is 18.7%. The likely reason for this is that in Andhra Pradesh only BPL families are eligible for JSY benefits. The functionality of ASHAs in those they did reach and translation to effective service delivery of health behaviour outcomes was much higher. This may be reflective of better base line. Even visits to newborn and postpartum visits were in the 50% range. Attendance in immunisation session was 75% in EG and 93% in Khammam. 96% of babies were weighed at birth and at 67% of these the ASHAs were present. One detail noted is that only 33% of children reported being immunised for measles. It becomes therefore difficult to comment on how much that change in health behaviour or reach of health services relates to value addition by ASHA. ASHAs value addition to many aspects of care in pregnancy and immunisation are therefore questionable. One also needs to explore how much of this variance is related to the new role of ASHAs as mobilising cases for HMRI.

In terms of illness care however the ASHA was much more active and over 85% children with diarrhoea had received assistance from the ASHA and 72% had received ORS. 30% of ASHAs in East Godavari and 16% in Khammam had ORS in their kit on the day of interview. ASHAs ability to make home ORS adequately was 45% and on non drug interventions it was in the range of 40%. ASHA effectiveness in family planning was similar to the Rajasthan but in Malaria and TB the performance was much better. 85% of ASHA received a payment of Rs. 500–1000 per month the rest have received less than. One interesting feature in Andhra Pradesh was that community mobilisation was very strong indeed with most ASHAs being active with a wide range of mobilisation activity. This matches very well with the programme theory that shaped the training process. It does seem that without effective supervision and without any support (for the supply of drugs or monitoring and a training focus on activism, we have in place in Andhra Pradesh an ASHA weak in both facilitation and effective response to local illness. Unfortunately the extent of mobilisation achievable under the circumstances is not enough to enthuse those who hold this view of the ASHAs role.

Community mobilisation was very strong indeed with most ASHA being active with a wide range of mobilisation activity. This matches very well with the programme theory that shaped the training process.

The Way Forward

- Immediately decide on programme priorities and based on this build up a monitoring structure and a schedule of review meetings and reports.
- Build up a schedule of training programmes. There has been no training for years now and no direction to the programme. Knowledge and skills are weak and need to be built up.

Build back a focus on key RCH goals with clarity on reaching the unreached sections. There is a need to study who these sections are, and how they are getting missed. Inputs from maternal and infant death review should help.

Mechanisms of payment need to be streamlined and move to blended payment, with greater incentive package. Adding newborn care to the package would help solve issues of adequacy in incentives as well as in skills.

Building up support structures at state, district and block level are urgently needed. This is a large programme with a large initial investment, but subsequently this ASHA programme has one the lowest annual expenditures amongst all states pointing to an almost complete withdrawal of attention and interest in the programme.

There is a strong understanding of limiting ASHA to facilitator roles, with some stated support to the activist role, not reflected in either the content of the programme or the nature of its support.

VII. Bihar

Bihar is a large state with high levels of poverty. It's IMR at 52 and MMR at 312 are areas of concern though amongst EAG states, these are better figures. In terms of health service delivery, the states record is very poor, especially on immunisation. Though the state has made considerable advances under NRHM, both its facility development and its outreach activities need much more strengthening.

The programme has had political support and also considerable political stability in this period. However there have been frequent changes in administrative leadership and a not too clear administrative priority for this programme at many points over these five years. There is a strong understanding of limiting the ASHA to facilitator roles, with some stated support to the activist role, not reflected in either the content of the programme or the nature of its support. The programme made one critical error when it outsourced the whole training programme to a para-statel body which did not have the skills or experience, interest or dynamism to roll out the training programme. Nevertheless the programme not only survives but does relatively well, given in the existing context of the poor baselines and the low expectations. That is one reason why one must consider whether in Bihar's circumstance we need different standards for evaluation.

The two districts of Bihar are so remarkably similar that one could describe them as one. (they were surveyed by two different teams several months apart). About 73% of pregnant women have been met by the ASHA and about 45% of sick children have received advice from the ASHA. However the number of visits made was over three times in only 60% for the women about the lowest for any state. Of those met over 80% opted for institutional delivery and of those who so opted 91% were accompanied to the site of delivery. Purnia with

a net of 59% of pregnant women being escorted for institutional delivery is the highest recorded district in the study!! That's the good news. The bad news is that those who received three ANCs was also the lowest – 21% and other than TT injections all other services and counselling needed were amongst the lowest. As in Rajasthan, but to a much greater extent, we find a very focused intervention to contact the women for promoting institutional delivery and just about nothing else. ASHAs helped the mother in getting JSY incentives in about 59% of pregnant women in Khagaria, but only 27% of women got this assistance in Purnia.

Newborn visits on the first day averaged 47% of those who were provided any service and ASHA present during weighing averages 70% – which perhaps reflects their acting as birth companion, for only 32% had more than two visits in the post partum period. Their contribution to identifying danger signs in the newborn was 37%, in those mothers who reported that the baby had a sickness. This still accounted for more than any other category of worker. Breastfeeding in the first four hours was 92% in Purnia and 72% in Khagaria. In Khagaria 39% had not kept to exclusive breastfeeding in the first three days. Knowledge about these aspects of breastfeeding were adequate. Knowledge of when to start weaning was 80%, but on quality of weaning food knowledge was very poor. Only 40% had started complementary feeding at six months.

Attending immunisation was reported by about 96% ASHAs, but ANMs and AWWs placed the actual level of attendance at immunisation at a much more modest 70% regular attendance in last three months. The measles immunisation rate was 55%, which for Bihar is probably a significant improvement. This could be compared with DLHS-III. Family planning promotion is also minimal.

Only about 45% of children with any illness had been even met by the ASHA. Of this lot, the number of children with diarrhoea were 120 and in 71% of them the ASHA was contacted and gave advice. Of the children with diarrhoea, 74% got ORS, but only 27% of them got it from the ASHA. In testing knowledge 77% knew that ORS had to be given. Only 45% could describe the preparation of ORS adequately and almost no one could mention the importance of continued feeding or increased fluid intake as important advice. Knowledge on ARI was much less, more so in Purnia, yet of the 25 children who had symptoms suggestive of ARI, 92% had sought care while 80% had received assistance from ASHA. Community mobilisation is minimal.

The picture in Bihar is of an ASHA who is very effective in promoting institutional delivery and improving immunisation but neither equipped nor supported for anything else.

The picture in Bihar is of an ASHA who is very effective in promoting institutional delivery and improving immunisation but neither equipped nor supported for anything else. (Most ASHAs could "take home" about Rs. 600 for every pregnant woman that opted for institutional delivery in comparison to Rs. 200 to Rs. 350 in many other states and this may have helped). The drug kit in Bihar has never been introduced, and what ORS packets are there are more in the nature of local initiative or sporadic support to this aspect. The training programme has in effect never gone beyond the first round. The second round was a non residential 12 days and the experience is that many did not attend fully and there are many sections yet to be covered. What was covered also had limited skill levels. There is no support structure in place.

It is tempting to state that the lack of training, supportive supervision and drug provisioning as causes to explain the programme's limitations in Bihar. But

putting it together with the phase I qualitative phase, we must consider the possibility-that the major gaps in the programme: lack of supervisors, lack of training, lack of drug kits are not accidental or unavoidable errors, but actually the conscious and planned rolling out of an understanding where the ASHA is shaped to be a passive link worker for just these two functions and consciously prevented from any other functions. Despite this, the ASHA, has exercised some agency of her own, and supported by peripheral health workers and block level personnel has been active in a fair number of functions – which is why some visitors of the programme are able to see a vibrant ASHA programme. However since it is based on a sort of spontaneity, these tasks are done in a way in which it is neither very consistent nor very effective. Another way of stating the conclusion is this – Bihar is not unable to take up a skilled based programme, because it has no support structure. It has failed to build any support structure because it has not wanted to take up a skill based programme. We did note that Bihar has relatively been amongst the most successful on two major facilitator functions and for those in programme theory-1 it could represent the real success of their understanding. But for those in the second framework of understanding also called programme theory-2, there is a huge lost opportunity here a willing, active workforce, which has not been leveraged for child or maternal survival or better community health except in such a limited manner.

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The Way Forward

All the general recommendations made in the next chapter are pertinent to the state of Bihar.

a) ASHA skills must be built in areas such as IYCF, promoting ANC and family planning, essential newborn care, and care of sick children.

b) The training of ASHA in Modules 5, 6 and 7 needs to be expedited through creating training systems and structures and involving NGOs in the field as support agencies to ensure quality skill based training for the ASHA.

c) Increased NGO engagement is also required to bring in an activist dimension to the ASHA.

d) Now that the support structure at the block and district structures are in place, they need to be sensitised to the programme and supported to provide effective supervision and improve programme effectiveness.

e) In order to ensure handholding and mentoring at the field level, the ASHA facilitators must be recruited.

f) Household allocation for ASHA would assist in ensuring increased coverage and reaching the marginalised.

g) The drug kit must be supplied and regular replenishment ensured in the PHC review meeting.

VIII. Jharkhand

Jharkhand is a state with a large poverty levels, geographic challenges and constraints and problems of left wing extremism which affect much of the state. The health services have one of the weakest baseline situations anywhere in

the country. Surprisingly its IMR stands at a remarkable 44. Its MMR is more consistent and stands at 312.

The ASHA programme and indeed NRHM itself has been constrained by the very unstable political leadership, frequent changes in administrative leadership and problems of mis-governance. Fortunately through these changes some continuity for the programme has been sustained by a loose coalition of four or five NGOs CINI, PHRN, ICCHN, Vivekanada Kendra, Ekjut etc. These have formed a Sahiyya support structure.

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Jharkhand's ASHA selection was more on the lines of national guidelines, but even the democratic processes of selection have their own group dynamics. The net outcome is similar to other states, but with some relaxation for educational level. Upto the time of the evaluation, support structures have not been put in place. Training was relatively better organised with a considerable improvement in content and delivery, but this does not make up for poor monitoring, poor support, failure to refill drug kits and a poor record of payments.

The number of pregnant women missed in coverage was the highest, and this along with a failure to convert home to institutional delivery in about half the cases attended to, leads to the lowest outcome in terms of women accompanied to the institution for delivery. This could be due to geographic constraints adding to social barriers and problems of programme organisation and support. Number of mothers visited thrice was low in West Singhbhum and relatively better – 71% in Dhanbad, and those who received three ANCs was 45% in West Singhbhum and 58% in Dhanbad – much better than in Bihar. In all other parameters also counselling on post partum care, making an ANC card, counselling on contraception, on five cleans for home delivery also the achievements levels though low were twice that in Bihar. The experience with getting payment for JSY was the weakest in Jharkhand and within that in Dhanbad – where only 19% of eligible women had got the payment. Post partum visits were about the same in Jharkhand but again at levels more reflective of spontaneity than programme design, but with more women having been counselled appropriately in such visits.

Immunisation sessions were attended regularly by 87% of ASHAs – a good figure, but the lowest amongst the eight states studied. This attendance is confirmed by ANM and AWW responses. Measles immunisation was 56% in Dhanbad and 70% in West Singhbhum. Knowledge of immunisation and complementary feeding was quite low, especially for West Singhbhum, but like in other states knowledge regarding initiation of breastfeeding, and exclusive breast-feeding was quite high. Performance in family planning is much less than in Bihar-with only 13% of ASHAs having successfully referred 2 cases per month for female sterilisation and 52% having referred none. Performance on IUD is marginally better with 27% of ASHAs, having referred cases, though still very low. Knowledge of choice of spacing methods is adequate in about two thirds of ASHAs.

Health practices of the newborn and young child (on breastfeeding, weighing the baby and weaning) was more or less identical to what has been described for Bihar. In illness care, of those whom ASHAs services reach, a large proportion do consult her in the case of diarrhoea (73%) or ARI (67%). The percentage who took ORS is about the same in both districts, though in Dhanbad none of

it could be given by ASHA herself. On the day of interview 13% of ASHAs in Dhanbad had ORS with them and 38% of ASHAs in West Singhbhum had ORS. Knowledge of making ORS, or other non ORS interventions in diarrhoea were weak. Ability to recognise pneumonia was weak. There is low availability of chloroquine in the drug kit, 32%. About 31% of ASHAs report being involved in any malaria control work and 21% for TB control.

Payments for ASHAs are also low, about 38% get less than Rs. 150 per month, 24% get in the Rs. 150 to 500 range, about 29% in the 500 to 100 range and only 10% above Rs. 1000 per month.

Community mobilisation and the functioning of VHSCs is however far better than in Bihar. This is so in every stage. Given the poor state of the health system, this no doubt acts as the main cement to keep this programme going. Jharkhand also has had a strong programme theory-3 influence in its shaping – a mix of a link worker and an activist role and there was always a much greater emphasis on social mobilisation. (This as we noted earlier is one particular interpretation of the Mitanin programme, and also have votaries for it quite independent of the Mitanin). There is conscious recognition of marginalisation and much more efforts to reach out to these sections, but as of now, it has been unable to reach to major sections of the community. Another feature we note, was that there was a limited amount of NGO involvement that was picked up in the questions on the selection process about 5%, but this was still higher than anywhere else. Similarly private sector referrals and nexus though low were still higher than in any other state and at the same level as Bihar This could also be due to the poor state of the public health system in these states.

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The Way Forward

As in Bihar the programme has to improve on so many fronts that the general recommendations made are also pertinent to Jharkhand, in the next chapter would cover all aspects. Unlike Bihar, Jharkhand seems to have enough internal resources in terms of NGO leadership to provide better resource support to the programme, but they need to be strengthened institutionally and empowered to help.

a) ASHA require substantial skill building in all areas of maternal, newborn and child care and therefore competency based training as included in ASHA modules 6 and 7, needs to be introduced and scaled up rapidly.

b) State, district and block level support systems need to be activated and strengthened in order to provide the supervision and mentoring required to make the ASHA more effective.

c) Home visits, particularly to the marginalised need to be emphasised through specific household allocation.

d) Payment mechanisms must be streamlined to ensure that ASHA are getting paid in a timely manner.

e) Drug kit distribution and regular replenishment needs to ensured in order for ASHA to be able to provide life saving support such as ORS.

f) The activist nature of the ASHA needs to be built and sustained through enhanced NGO involvement with the programme.

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Key findings – A Synthesis Across States

Five years after the onset of the programme, drop outs are minimal and the programme continues to expand. Political support is strong. The ASHA herself is enthusiastic and every description of the NRHM points it out as one of the programme's great strengths.

1. This time around the scaling up of the Community Health Worker (CHW) programme seems to have survived and established itself despite the odds. Five years after the onset of the programme, drop outs are minimal and the programme continues to expand. Political support is strong. The ASHA herself is enthusiastic and every description of the NRHM points it out as one of the programme's great strengths. It is not certain what impact it has on maternal and child survival, but certainly on the two most often required outputs of the programme the promotion of JSY and institutional delivery, and the promotion of attendance on immunisation day, the programme has most definitely succeeded in all states and under all circumstances.
2. Nation-wide there are 820,000 ASHAs and this could rise further, giving rural India, one ASHA for a population of 1000, resulting, in a population ratio of one per 1000. The density of ASHA deployment varies across states and the trend is to have more ASHAs, than the stipulated one per 1000. Of the states studied, Rajasthan has 1: 1062, Orissa 1: 1007, Bihar 1: 1006, West Bengal 1: 1000 (normative not actual, for the areas deployed), Assam 1:880, Andhra,1: 829, Kerala 1: 764, Jharkhand 1: 564. In the tribal areas of West Singhbhum, Jharkhand, Khammam, and Banswara, ASHA density is less than one per 500, for 25%, 36% and 19% of ASHAs respectively. In most states, over 50% of ASHAs cater to a population of less than 1000. In West Bengal 60% cover more than 1000 population. These variations indicate that states have been interpreting the central norms to suit their context.
3. The selected ASHA conforms to the expectations of the programme in all the states studied. She is as per the guidelines, almost invariably a woman resident in the village and literate, with at least 8th class education. The provision for relaxation in literacy has not been widely used, except in tribal areas of Orissa, Jharkhand and Andhra Pradesh. Most villages have either found ASHAs who were literate, or this has been insisted upon by the authorities. The inability to relax the educational level where needed and raising the educational level even higher, as in West Bengal to class X has resulted in failure to find ASHAs in some of the neediest areas as indicated by the finding of the qualitative component of the study. Most ASHAs come from poor households, and the proportion of ASHAs who are SC or ST is equal to or more than the proportion in the population. Minorities are however be under-represented in some of the states in a few districts.
4. The selection process laid down in the guidelines specifies a sequence of events: starting from community mobilisation, with facilitators helping in enabling weaker sections to articulate their choices, gram sabha meetings, and finally Panchayat endorsement of the final choice. The entire sequence has almost never happened. In four states, Assam, Andhra, West Bengal, Kerala, a formal multi-stakeholder committee assigned by the government with this task, made the choice. The outcomes are quite acceptable in terms of profile and motivation, though financial considerations as a reason for becoming ASHA are much more prominent in West Bengal. In Orissa and Jharkhand the mobilisation component was stronger, but Panchayat involvement was weak. In Orissa, meetings of women self help groups facilitated

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by AWW and ASHA make the choice and in Jharkhand it was the VHC. In Bihar it was the ANM making a decision in consultation with Panchayat and members of the community, or the Panchayat taking leadership and making the choice in consultation with the ANM and rest of the community. In about 20%, the selection has been made even without such consultations. In Rajasthan it was the Sahayogini of the ICDS programme who was converted by an administrative fiat into the ASHA. The Sahayogini itself had a selection process similar to Bihar but with the AWW playing the lead role. On triangulation, there is considerable difference between different accounts on the participation and role of the four different stakeholders in the selection process-the PRI, the AWW, the ANM and the community level meeting – a point to be kept in mind when future researchers enter this field. There is no clear evidence that the choice of process made much difference to overall outcomes as the contribution of other factors overshadows this dimension. The much feared phenomenon of the "relative of the Panchayat being appointed" has not happened at all.

5. Every ASHA was asked why she chose to become an ASHA from a set of nine responses, and to rank the top three in order of importance. The desire to serve the community emerges as the foremost reason for becoming an ASHA, well above all other factors. 80% of all ASHA across the districts reported "serving the community", as one of the top three reasons. The second most important reason was the financial aspect of being an ASHA. Although only about one in four ASHA reported financial need, as the first reason this accounts for one of the three reasons among 50% of ASHA across the states. The third most important reason, getting a government job was stated as the first reason by only 5% of respondents. For 15% to 30% of ASHA it was one of their first three reasons.

6. Establishing a management and support structure at various levels has been weak in all states studied. Assam with all the support structures in place, clearly needs much more capacity building of its facilitation teams. Orissa needed to put in place the sub-block ASHA facilitator. Rajasthan has all structures in place, but they need more content, depth and skills to be effective. Orissa has the most functional review process in place, with a clear schedule of meetings and some mechanisms of recording and measuring progress. Jharkhand has state and district level structures. In contrast Andhra, Kerala, and West Bengal had no full time support structures in place at any level. This bleak scene is ameliorated by some favourable factors. Andhra Pradesh had a more motivated DPHNO – though despite this, it was perhaps the most weakly monitored and supported ASHA of the eight states studied. Kerala had a good schedule of meetings and the ANM (called JPHN) was much more available for playing this role as her work had either shifted up to the PHC or been shifted down to the ASHA-making her a supervisor of an ASHA with little work outputs of her own. In West Bengal, Panchayat and field functionaries formed a viable administrative support team, though this was of little use in providing clinical support. Much of the weaknesses of the ASHA programme can be traced to this weak support structure. The guidelines are explicit on this, but that did not prevent the states from not following up. Some state officials pointed out that there was little follow up for this aspect of the programme from the centre.

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7. Content of training modules, especially of training module 2, which covers a wide number of vitally important topics, is not competency based. There were no guidebooks for trainers. The modules were too incomplete to be effective. There has been no in-built training evaluation. Despite this limitation, many states have innovated on training modules and on training programmes and final outcomes of training are encouraging. Where the modules are effective, the training outcomes are adequate- but such areas are few.
8. ASHAs were expected to receive 23 days of training per year. Of the ASHAs who received trainings, about 97% of ASHA in Bihar have received less than 16 days of training, of which 87% had received less than ten days, over a four year period. In Jharkhand this figure is 92% with 50% receiving less than ten days. In Rajasthan 31% of ASHA had received less than 16 days of training, with the remaining 69% getting more than 16 days. In Orissa about 86% received more than 16 days training of which nearly 54% had received more than the targeted 23 days of training. In Assam 77% received more than 16 days, of which 26% had received more than 23 days. In West Bengal, 90% had received 23 days of training. In Kerala, 52% had received over 16 days. The slow pace of training relates almost directly to the human resources deployed for training. States have largely relied on trainers, drawn from existing human resources, possible to spare within the system, as in Kerala, or sourced in from appropriate NGOs, or recruited full time-as in Assam or Orissa. Where training relies only on internally available, already busy staff, the training programme has languished.
9. **Payments:** The experience of payment varies widely across states and within states. Assam, Orissa and Kerala are purely performance based with robust mechanisms of accounting and timely payment. West Bengal has a fixed amount system paid regularly, within a well implemented system, and Rajasthan a blended system of fixed plus performance based mechanism, with delays and irregularities. Andhra, Bihar and Jharkhand have performance based payments which are poorly implemented clearly co-relating with the lack of a management-support structure in these three states. In Andhra Pradesh and Kerala, the problem is compounded by JSY being a poor yield opportunity on account of lower fertility rates, and because only BPL women are entitled for JSY payments. There is no clear relationship between the level and modes of payment of payment. In Orissa, bank transfer was the major mode, and in Assam and Rajasthan it was mix of all three-bank transfer, cheque and cash. In Jharkhand and Andhra Pradesh it was a mix of cash and cheque and it was predominantly cash based in West Bengal, Kerala, and Bihar. The mechanisms of payments in Orissa and in Assam are worth emulating in other states.

All states have an expenditure on this programme which is less than a third of what is allotted for this programme, and the primary reason for this is the inability or unwillingness to invest in management and support structures at state, district and block levels.

10. **Financing:** The ASHA programme is budgeted at Rs. 10,000 per ASHA per year. Even after allowing for a late and slow start to the programme-states should have incurred a sum of Rs. 30,000 across the years 2007-08, 08-09 and 09-10. What we find is that Assam expended Rs. 12,546, Kerala, Rs. 10689, Orissa Rs. 9532, West Bengal Rs. 8300, Rajasthan Rs. 7529, Jharkhand Rs. 7348, Bihar Rs. 3373 and Andhra Pradesh Rs. 1719 in this period. All states have an expenditure on this programme which is less than a third of what is allotted for this programme, and the primary reason for this

is the inability or unwillingness to invest in management and support structures at state, district and block levels. This is also reflected in poor pace of training and no doubt impacts on the quality of training as well. Expenditure rates are also an accurate reflection of the quality of political and administrative support the programme enjoys as measured by the willingness "to put their money where it matters."

11. Drug Kits have been provided in all states, except in Bihar and even then only selected drugs were provided. There is a massive problem in all states regarding drug kit refill and this is probably because there are very poor drug logistics in place and because there is considerable under-estimation of the demand. A kit based supply should be used only to supply the bag, the first time around. After this the focus should be on the use of stock cards and a responsive supply side management.
12. There is no evidence of any major conflict between ANMs, AWWs and ASHAs though this is one of the most commonly heard problems as perceived by the programme managers. There could be two reasons for this: One, it is because the early conflicts are all over, and each is used to the other being there and no longer feels threatened. Two, it is because the incentive is now clearly in different silos and there is no competition for the same incentive. Thus for institutional delivery only the ASHA gets the incentive, and for family planning the ASHA almost never gets any. Perhaps this conflict was never such an issue except when these three workers were set at each other by, "the same incentive having to be given to only one of the three; all of whom were declared eligible to get it for a task that all three had to do as part of their job descriptions." With the confusion over incentives resolved, by order from above, (as in the case of the JSY incentive where the guidelines stipulate that only the ASHA is eligible to get it), or decided at the field level (in the case of the sterilisation incentive, which goes to the ANM and rarely the ASHAs), the conflict over this issue has reduced.
13. There is as a rule no major issue of role clarity between the three key functionaries at the field level and this is borne out by the beneficiary interviews and findings from the qualitative study. The ASHA acts at the level of the home and community on a day to day basis, whereas the ANM visits the AWC once or twice a month, and rarely visits the home. The ASHA brings women and children to the immunisation session and the ANM provides the immunisation and ante-natal and family planning services. The first line of care for common coughs, diarrhoea and fever and aches and pain is the ASHA. If the ANM is available and the illness is unresolved or beyond her level of training, then she (the ANM) becomes the first referral support for the ASHA, if necessary making the home visits which are "prioritised" for her by the ASHA. Otherwise in practice the ANM does not make home visits at all. The Anganwadi worker has a focus on running the Anganwadi centre, providing supplementary food cooked or take home rations, undertaking growth monitoring and pre-school education. Home visits by the AWW are prioritised for the prevention and follow up of malnutrition and anaemia. The AWW is not active on management of illness and the community is not turning to her for these services. The logic is different in Kerala, where since the ANM does not have much work in delivery of immunisation services, midwifery or even care in pregnancy she could therefore spend more time

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on home visits. Here an actual shifting of ANMs work to the ASHA has possibly occurred. What has shifted in other states is the notional work of the ANMs (tasks that were on the ANMs list, but which she never did anyway because of constraints of time and availability) especially the task of routine home visits to all pregnant women and young children for counselling and early management of common illness. This is clearly the reason why the ANM welcomes the coming of the ASHA. In counselling for nutrition and supplementary food for the below two child, the ASHA is clearly under-skilled, under-supported and non functional, and there is no evidence that the AWW or helper has taken this up either. Duplication in this task would be welcome, and a reinforcement of a difficult-to-reach goal-as long as primary responsibility for his task is fixed on the ICDS system.

There is no evidence of ASHA charging fees, or setting up private practice, or becoming a dai or even of becoming a tout of the private sector.

14. There is no evidence of ASHA charging fees, or setting up private practice, or becoming a dai or even of becoming a tout of the private sector. At this point of the programme we can safely say that this much feared problem has not happened. This is not to deny anecdotes. There is anywhere from a 1% to 5% of private sector commissions, across the states, rising to 10% in one district and that could generate a huge number of anecdotes.

Detail tables on finding of the study can be accessed on http://nhsrcindia.org/thematic_data.php?thematic_resources_id=1

Is the ASHA Programme Working?

In the first framework of understanding, the ASHA works by generating demand. Services, all services, are provided by professional health care providers, and the ASHA assists by ensuring that their services are fully utilised. In the second framework of understanding, the ASHA is effective because she reaches out to many sick children and newborns with a level of care that is life saving. If she fails to reach the child no one else will.

There are three clearly different explanations of how the ASHA programme will work. Each of these three programme theories or "frameworks of understanding" as we have called them are likely to make different meanings of the evidence being placed before them. But we hope that as everyone, including the researchers mull over the data, we come closer together in our understanding of the programme.

In the first framework of understanding, the ASHA works by generating demand. Services, all services, are provided by professional health care providers, and the ASHA assists by ensuring that their services are fully utilised. The ASHA cannot and should not provide any other type of care, though some health education leading to changed health practices, especially those that lead to greater consumption of health services are welcome. Typically the officials who hold this view look only to the public health system for providing this care, but there is a section of administrators and public health experts who feel that private health care providers should also be roped into this response. The ASHA's getting into service provision is not desirable because a) it would make the public health system provider lazy and b) The ASHA would then set up practice as quacks and c) The ASHA would then demand for becoming permanent staff. Mobilisation for attending the facility is welcome, but all other forms of mobilisation are not welcome or at least not feasible. Most votaries if this view also hold that there is a constant strife between ANM, AWW and ASHA at the field level. They also would hold the view that better payments would lead to better coverage. This framework of understanding is highly prevalent in the state level amongst all implementers and in the district level amongst medical professional leadership of the programme.

In the second framework of understanding, (Programme theory - 2), the ASHA is effective because she reaches out to many sick children and newborns with a level of care that is life saving. If she fails to reach the child no one else will. Potentially the AWW can, but in practice because of structural issues, the AWW is not doing so. This theory recognises how important it is for the ASHA to have the support of a responsive health system that heeds her referrals for saving lives and for her own credibility and sees the demand generation role as a major role. But it also holds that those who are unreached or marginalised can be reached only if their felt needs are being responded to. This theory also recognises that when the system is not adequately responsive, the ASHA should also be trained and supported to be activist enough to persist, push for entitlements and mobilise weaker sections to access these services as their rights. But given the structure of implementation, there are limits to mobilisation. The key issue is that even if the system was responsive, without actually being able to respond to illness needs at the home level, the ASHA programme cannot be expected to have any impact on child survival and the real potential of this programme is lost. Drugs are not central to this response, but an active form of counselling which requires higher level of knowledge and skills is the most important requirement and actually constitutes a form of service provision. However some drugs – notably – paracetamol, co-trimoxazole (or other anti-biotics), chloroquine (or other anti-malarials), and ORS are critical to her work. Fragmented payments by incentivisation of specific tasks should not be the sole source of support and should be combined with fixed payments. This view is the most prevalent view of the programme in professional public health literature, in much of civil society and in the national leadership as represented in the ASHA Mentoring Group. It is also a view commonly held by ANMs, ASHAs and most block level functionaries. In Orissa, the state leadership also has this understanding.

In the third framework of understanding, the ASHA programme works because her role in securing community participation and mobilisation is effective in itself.

In the third framework of understanding, the ASHA programme works because her role in securing community participation and mobilisation is effective in itself. It enables facilitation tasks, reaches the unreached, and mobilises communities into putting pressure for functional health systems. Payments are considered to be a hindrance. Service delivery would distract, although some basic services are useful as a supplement to mobilisation. Not too much is expected of the ASHA in saving lives in the field. Some would say it is because she is not qualified for this, and others would say it is because the system cannot be expected to provide the high degrees of support and training required to realise this. One sees a strong evidence of such views in Andhra Pradesh (especially the training content) and Jharkhand programmes. It is also a prominent view among some sections of civil society and some sections of state and national leadership.

We present the functionality and effectiveness of the ASHA in relation to these different frameworks of understanding and raise some key corollary questions that emerge within each framework, when the understanding interacts with the evidence.

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The Facilitator-Link Worker Role

As a limited facilitator of two services, i.e., getting pregnant women to the institutions for delivery and getting pregnant women and young children to the immunisation session or VHND as it is called the ASHA is remarkably effective

and the programme is clearly "successful." If one is in the first framework of understanding, the ASHA and the ASHA programme should not be held responsible for anything more. The impact of these two changes on health indices would be more determined by the existing responsiveness of the health systems-its ability to deliver services in the facility and in the VHND platform. Those who would consider this as adequate should reflect on the following:

a) Does the poor coverage reflect the failure to promote facility utilisation in those sections that are not already sensitised to it? Are most of the users of the services "anyway" or "already" users of the service? This is clearly so in a context like Kerala, because of such a good baseline. But to what extent is it so in other states? The finding that in many states women who finally opt for home delivery have usually not been met by ASHA or offered any other services is a matter of concern. It may be unfair to dismiss ASHAs as merely being commission agents as those in other frameworks of understanding do, but then there is a need for those who passionately believe in a limited link worker ASHA to at least ensure universal coverage for these two limited goals.

b) Many marginalised sections may respond better to the call of institutional delivery or immunisation if their felt health care needs, particularly illness in the young child are attended to.

c) Is it that the promotion of services is so narrowly linked to what is incentivised that even related changes in health behaviour needed for effectiveness in health outcomes are not being achieved?

d) Within this programme theory there is still scope for improvement in family planning services where indeed ASHA, ANMs and AWWs compete over the incentive, and across the board, the ASHA does not seem to be getting any incentive.

Facility level care and quality of outreach services would have to improve dramatically in the high focus states for the "only demand side ASHA" to be effective. Most state programme managers have a stated commitment to enhance the activism component, and this could be built on to achieve universal coverage. Some spirit of activism is also needed to widen the scope of interventions at least to associated health care practices like hand washing or adequate complementary feeding, or even to three ANC check ups instead of being so narrowly limited. But eventually those within this understanding must reconcile to the fact, that no major increase in child survival is likely from an ASHA limited to this "facilitator" role.

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The Community Level Care Provision Role

As a person responding to health care needs of the community and effective in changing health behaviours, the success of the programme at this point of time is limited. If we understand that much of child mortality is due to diarrhoea or ARI and most lives could be saved in our context by the provision of immediate home based first contact care or that most newborn deaths can be averted best by providing essential newborn care at facility or at home, followed by home based follow up for a month, or due to malaria which needs prompt diagnosis and appropriate care, then the current ASHA programme falls far short. And yet, for both public health science and for civil society this was articulated as one of the main reasons for embarking on and supporting the ASHA programme.

Orissa seems to be most responsive and effective on this dimension. West Bengal and Assam are functional on this aspect but need more inputs to be effective. The other states have to take this seriously – but for this they would need to understand the ASHA as more than demand generation. The states could be encouraged by the finding that this is possible and there is considerable welcome and initiative for such care provision at the field level. ASHAs are already functional in care provision in about 50% of illness episodes and visiting newborns within three days, even without much encouragement. It is not the lack of motivation or incentives that is coming in the way. It is just that they need the skills and support to be effective. This is the case with promotion of better health care practices and healthy behaviours. Currently monitoring and support systems are not even asking these questions of the ASHA and not reviewing the programme for achievements in these areas. Skills too are insufficient.

In non communicable diseases, an ASHA limited to bringing adults to attend NCD camps becomes sub-critical. There is a need to invest her with skills of screening and routine follow up for diabetes and hypertension if she has to make a visible impact.

Kerala is also active on this dimension, but given existing health seeking behaviour for childhood illness and for care in pregnancy, the ASHAs value addition is not clear. In non communicable diseases, an ASHA limited to bringing adults to attend NCD camps becomes sub-critical. There is a need to invest her with skills of screening and routine follow up for diabetes and hypertension if she has to make a visible impact.

For those with this understanding of the programme, the questions are

a) How to build up skills when there is such great hesitation to invest in a supervisory and training structure?

b) How to ensure regular drug supplies, when overall drug logistics is still so weak?

c) How to make full use of the window of opportunity that exists because of the ASHAs current level of functionality, when incentives and monitoring structures fail to factor in these tasks. This is most important to secure changes in health care practices as well as to save child lives through prompt and simple actions undertaken at the home and community level.

There are best practices in the states from which we can learn. What is important is to understand cause and effect on the challenge of building up supervisory and training structures. It is not that we cannot impart skills because training and supervisory structures are deficient. It seems more that these structures are deficient because at the level of implementation there is reluctance to concede these skills. If that hesitation, partly a result of professional mind-sets changes, then the practical problems of building a supervisory structure and mechanisms can be resolved more easily. So though success in this area is limited, given the limitations of training, support and incentivisation, the fact that so much progress has been made at the field level even in the so called poor performing states is encouraging.

It is not that we cannot impart skills because training and supervisory structures are deficient. It seems more that these structures are deficient because at the level of implementation there is reluctance to concede these skills.

The Second A(ctivist) in ASHA

The findings are that this role of ASHA as activist is rather limited. Though perceived as important at the senior levels, the more proximate (district and block) levels do not hold the same view. Even in states where there was a major initial thrust given in this direction, as in Andhra Pradesh and Jharkhand

this has not been sustained in the nature of support provided, though even now, much of this energy sustains in these states. Jharkhand did select NGOs for this support, but either due to poor choice or poor support to the NGOs themselves, there was limited progress, and the state withdrew from this option. Yet in the absence of serious and systematic NGO involvement, it may be difficult to secure this aim.

That activism could also mean greater efforts to reach marginalised sections within the village not only insist on more functional health facilities has not become obvious to many functionaries. The design element that an ASHA helps by helping marginalised sections access health care facilities is not understood by programme implementers at any level.

The first four modules completely ignored the activist aspect and. Module 5 was introduced as a corrective. In Orissa and Assam module 5 has introduced many elements of activism through leadership and empowerment and this is apparent, although to a modest extent. In other states including Andhra Pradesh, Kerala, Bihar, Rajasthan there is not much enthusiasm in introducing this module, and two years after its introduction, the module is yet to be rolled out.

What was existing mobilisation most associated with within a district ? We looked for a number of statistically significant relationships. In Birbhum, ($p = 0.001$), in Nayagarh (0.02), in Purnea (0.014) and Khagaria (0.001), and in Trivandrum (0.035) there was a strong association of this with the active presence of a Village Health and Sanitation Committee in which the ASHA was actively involved and irrespective of her formal position in it.

The findings however demonstrate that community mobilisation in the form of VHSCs does pick up, especially after module 5. That activism could also mean greater efforts to reach marginalised sections within the village not only insist on more functional health facilities has not become obvious to many functionaries. The design element that an ASHA helps by helping marginalised sections access health care facilities is not understood by programme implementers at any level.

The good news however, is that many ASHAs may have a better understanding of this dimension, and there is a large amount of "spontaneous involvement" in a wide variety of mobilisational roles. There are trends of mobilisation for the ASHA's own wages-but what we have traced is the wide degree of mobilisation that she has led or participated in for securing community entitlements. This needs to be built on. While financial reasons may be a driving factor in about half the ASHAs selected, any careful reading of the evidence should concede that altruistic reasons, such as community service also act as a driver in about half the ASHAs. This should not be dismissed out of hand merely because planners and implementers may lack such motivation. The insistence on planning for incentives and payments and career plans is good and needs to be encouraged. But planners must also plan to support and develop the voluntary and community service dimension of the ASHA programme.

Those who believe that activism is the main way that ASHA programme would be effective should recognise the limitations of achieving such a goal without a parallel structure of implementation.

Those who believe that activism is the main way that ASHA programme would be effective should recognise the limitations of achieving such a goal without a parallel structure of implementation. Since this is not desirable, they would have to focus on improving three dimensions of the programme – a). Sensitisation of the ASHA and the programme to reaching out to the marginalised, b). Building up mechanisms of meaningful NGO involvement either through appropriate central schemes or state level grant in aid mechanisms and c). A strong VHSC programme supported by NGOs to focus on community entitlements and provide the opportunity for ASHAs to contribute as an activist.

CHAPTER 7

Recommendations

Based on these findings, we make the following recommendations. These recommendations are in addition to the state specific recommendations made in the earlier chapter.

1. There is an urgent need to reiterate to the states that the ASHAs role must be seen as being composed of four major activities-
    a) **Home visits:** Especially for those homes with a pregnant woman or a newborn or a child below two years or a malnourished child or a child below five who is sick.
    a) Attending the immunisation session or Village Health and Nutrition Day (VHND).
    b) Periodic and regular visits to a health facility for training, for programme review or for escorting a woman for delivery, or a sick child.
    c) Holding village level meetings.

For efficient utilisation of her time and the considerable investment, programmers should maximise the health gains from each of these four opportunities. The home visits should be used for counselling leading to changed health behaviour. Home visits would also be used for providing a level of first contact curative care, universally accepted as being within the capacity of community health workers to provide. The village health and nutrition day and the village meeting should be leveraged for behaviour change communication and social mobilisation. Currently home visits and the ASHAs attendance in immunisation sessions are missed opportunities for key community level health interventions. The two key requirements to ensure that the time spent on these activities translate into health outcomes include:

    a) Increasing the knowledge base and the skills of the ASHA through training and on the job supervision.
    b) Ensuring a health system that is responsive to her referrals and provides requisite supply side inputs.

2. In order to improve the effectiveness of the ASHA, and realise the full range of interventions that can take place through home visits, VHND, and coordinating VHSC, further skill building in the following areas is required:
    a) Improve the skills of counselling and inter-personal behaviour change communication in a number of areas related to nutrition, care in pregnancy, home based care of the newborn, and prevention and management of illness in the young child, and prevention of common

communicable disease and promotion of good health practices. (The detailed set of competencies of the ASHA has been listed in the Operational Guidelines for Maternal and Newborn Health, Ministry of Health and Family Welfare, 2010.) Much of this is not happening now, because the effort to monitor and support the ASHA on these activities and provide on the job mentoring to enable her to perform these functions effectively is not being emphasised. The training programme covers these areas, but skill building in counselling needs to be aimed for and accomplished.

b) Build competencies to recognise and refer maternal complications, provide appropriate community level care (including first contact curative care) of newborn and child hood illnesses and other diseases such as malaria and tuberculosis.

c) Build skills in village health planning and in organising her own tasks.

d) In areas where non communicable diseases are a looming threat, build the skills of the ASHA in screening for blood pressure and diabetes.

3. To address the problem of inadequate *coverage* of the beneficiaries, the ASHA's role in reaching out to marginalised sections needs to be emphasised. The trend amongst ASHAs to limit their support in pregnancy to those women who are more likely to opt for institutional delivery needs to be corrected. Active sensitisation is also needed to convey what marginalisation means and the need to emphasise to the ASHA that she needs to prioritise these sections. In order to elicit a positive response to the department's priorities, from such communities, their felt health needs must be attended to. The evaluation shows that representation of SC/ST and the population coverage are not issues in the programme, but social barriers restricting coverage leading to a significant minority within the village who are not able to access ASHA's services is a problem. There needs to be a renewed emphasis and support to enable her to identify and overcome social barriers and to ensure that every single house in a rural area is allotted to one ASHA and that every house is reached by the ASHA.

4. There is a persisting need for advocacy to explain to programme managers, the potential gains of having an ASHA in place. The Task Force Recommendations that set up the ASHA programme, and the document that emerged from this, (Accredited Social Health Activist (ASHA) Guidelines, Ministry of Health and Family Welfare, April 2006) should be made widely available. In particular the rationale of how the ASHAs home visits can save child and maternal lives needs to be understood. This would be particularly important in blocks where the nearest referral point is not within the village, and hence without the ASHAs intervention, there would necessarily be a delay in identification and prompt provision of appropriate care.

   Where skills to save lives have not been imparted, no expectation should be made of health outcomes from a ASHAs role, except to the limited extent that increases in institutional delivery and immunisation rates alone would make a difference. Globally, neonatal deaths account for nearly 40% of under five deaths, 13% from pneumonia, 14% on account of diarrhoeal deaths, malaria 9%, and measles 1%. (WHO, 2008). Other studies have demonstrated that two interventions—oral rehydration therapy and breastfeeding—were each estimated to prevent over 10% of deaths. Six further interventions could each prevent at least 5% of child deaths, and these include ITMs, improvement of complementary feeding,

antibiotics for neonatal sepsis, antibiotics for pneumonia, antimalarial treatment, and preventive zinc supplementation[11]. An 18–37% reduction in neonatal deaths can be achieved with outreach and family-community services alone. Effect at the family-community level might also be increased through more comprehensive community case management of illnesses in newborn babies, such as neonatal sepsis and birth asphyxia, effectively taking more clinical care into the home and community[12]. Other studies show that community health workers can undertake these tasks provided they are well trained and supported. Thus all of these interventions are well within the purview of the ASHA and the life saving potential of home based newborn care has also to be explained more rigorously.

Mechanisms that provide incentives for these activities, and regular drug kit refills and on the job training are essential support this work. The number of children identified and admitted as sick newborn or diarrhoea with dehydration or for pneumonia, or cases of malaria picked up by ASHAs could be easily monitored under existing systems. Such monitoring and feedback would enable maximising health outcomes of these interventions. Currently the main limitation to ASHA being more effective in these areas is not her own educational or even skill levels, but the quality of support she receives and perceptions of her role at higher levels of the implementation chain. As long as this persists, the ASHA programme would fall far short of its potential.

5. Advocacy to explain the activist dimension is also essential. NGOs associated with the Advisory Group on Community Action (AGCA), community monitoring process and the National ASHA Mentoring Group must be supported by the MoHFW at the national level to explain the programme, especially the rights component, to the programme managers at district and sub-district levels.

   The activist component should be understood primarily as reaching out to marginalised sections with a greater effort, and ensuring that people are mobilised at the village level to utilise services and undertake collective action needed to safeguard health, including access to health related entitlements. At the sub-district, level advocacy for the community care role is not so urgent, as stakeholders at this level largely understand and agree with this aspect. But the ASHAs role as an activist for securing health care as entitlements would need explanation. The department would be a poor vehicle for facilitating this, though with sensitisation even they could do better.

   Strengthening and orientation of ASHA mentoring groups at the state level would be essential for sensitisation of state level officers. Here the challenge is to bring in public health expertise from civil society that has worked in the theory and practice of community health action to explain the link between community level care and child mortality and the minimum level of skills this needs. This was the vision with which the ASHA mentoring groups were created, but in most places they are too poorly functional or constituted without the participation of such a civil society representation to effectively play this advocacy role.

11 How many child deaths can we prevent this year?, Gareth Jones, Richard W Steketee, Robert E Black, Zulfiqar A Bhutta, Saul S Morris, and the Bellagio Child Survival Study Group*, Lancet Child Survival Series, Vol 362 • July 5, 2003.

12 Evidence-based, cost-effective interventions: how many newborn babies can we save?, Gary L Darmstadt, Zulfiqar A Bhutta, Simon Cousens, Taghreed Adam, Neff Walker, Luc de Bernis, for the Lancet Neonatal Survival Steering Team* Lancet Neonatal Series, March 2005.

The national ASHA mentoring group, which is a carry forward of the task force that designed the ASHA programme and which in turn was constituted subsequent to an intervention made by civil society with the Prime Minister's office has also to recognise that it was not enough to have framed the guidelines. It needed to understand the need for advocacy to explain and support the decision on a continued basis, if the programme has to yield results in terms of child and maternal survival and in terms of social protection from costs of care.

6. Improving effectiveness of the ASHA is directly related to having a strong support system in place. Such a system must have the following essential components:
   a) Drug kits and regular replenishment.
   b) Financial and non financial incentives to give value to the task and to compensate the ASHA.
   c) Monitoring Strategy.
   d) Supportive supervision and on the job mentoring.

Each of these are elaborated below:

7. **Drug kit:** Improvement in drug kit refill is important and ranks as the ASHA's third most important suggestion for improvement. Where ASHA facilitators are in place, they should be given the task. Where not yet recruited, one peripheral staff member, such as the ANM, should be designated as the ASHA facilitator and given the task of refilling the drug kit. A demand responsive logistic system reaching out to sector PHCs and to sub-centres is essential for maintaining the drug supply needed.

8. **Incentives:** The study findings highlight a range of issues related to the payment of incentives. The following recommendations emerge:
   i) Currently the ASHA incentives are mainly dependent on the JSY payment. The guideline (existing, but requiring emphasis) is that Rs. 200 is for promotion of the delivery, to be paid to the ASHA even if she does not escort. Any delivery from the village which is institutional should be eligible for the incentive. Verification of the ASHAs role in promotion could be kept at a minimum even a statement from ASHA or the mother would be enough. Rs. 250 is for the transport and paid to whosoever arranges and pays for transport. If ASHA does not arrange the transport, she is not entitled to it. Rs. 150 is for the escort function and is paid only if the ASHA accompanied the woman. The insistence on the ASHA staying and linking payment to pregnant woman for 48 hours is perverse and plays no role, especially since she is not equipped even for a birth companion role. Even the escort function should be seen as voluntary and not made mandatory. However we recognise that in a significant percentage of cases the ASHA does undertake the escort function for a range of reasons in response to people's requests and in such situations, the hospital should facilitate the stay. A room for ASHAs to rest in and stay overnight, with access to toilets at every facility where ASHAs brings in pregnant women for delivery should be insisted upon. A facilitation desk in the CHC and district hospital to specially help ASHA and the patients she refers should also be insisted upon.
   ii) Across all states even where ASHA are active on promoting sterilisation they do not receive the full incentive. This needs to be attended to and

where ASHA has made a claim and the beneficiary names her, even as one of the many promoters, she should get the incentive. In case another peripheral worker has equal claim to the incentive, there needs to be a mechanism to ensure that this does not become a source of conflict.

iii) Incentives from all other sources are useful, but do not add up to a significant sum, per ASHA. The only exception is where visits to the newborn are included. The provision of incentives for newborn visits at Rs. 200 per newborn visited (as seen in Angul district) makes the amount received by the ASHA increase significantly. Based on these considerations, we recommend Rs. 250 be paid for a series of five visits to the newborn. In areas where institutional deliveries are low, this would result in the ASHA reaching home deliveries which are otherwise neglected. In low fertility areas, this incentive would add to the otherwise low sum that JSY alone currently provides.

iv) Fixed monthly honoraria do not make a difference to the range of services provided or to the functionality of the ASHA. It is the nature of programmatic emphasis and quality of support that is critical. Performance based incentives certainly help improve the performance of the task to which it is linked. But whether this task is narrowly understood and performed like a commission agent, or undertaken in such a way that it impacts on health outcomes, again depends on the quality of training and support. For example motivation for an institutional delivery could be focused entirely on ensuring that the woman delivers in an institution, (a narrow definition), or enabling antenatal care, counselling for nutrition and contraception, etc., Incentivising newborn care makes the performance based amount add up to a substantial amount which is higher than what is being considered for payment under the fixed route. We note however that the case for a fixed monthly honorarium is made by its votaries mainly on the rights of the ASHA, who is usually a poor woman and who is spending on an average three to five hours per day on this work. A basic performance based retainer payment linked to a set of monthly regular activities – maintaining her diary, maintaining her drug kit and dispensing from it, conducting home visits to all families at risk (pregnant women, women with children below 2, malnourished children) once a month, holding the village women's meeting, and where she is the member-secretary convening the VHSC could qualify her for Rs. 500 per month, over and above which she would get performance based incentive for specific activities.

9. A system to monitor ASHA functionality and effectiveness needs to be put in place at block, district and state levels. The block level would use a set of indicators reflecting functionality on a range of services, the district would use a sub set of the block indicators, as appropriate, and the state could use one or two indicators. These indicators would be based on data collected from ASHAs at the monthly meeting or in the training programme or on data collected and verified by the ASHA facilitator. The block, district and state would in addition review ASHA effectiveness through five health outcome indicators from the HMIS already being generated. Such a system is possible, and indeed essential if there is a system of facilitators, block coordinators and district coordinators in place. It would be very difficult to implement without full time staff dedicated to supporting the ASHA and VHSC programme. The block (and units below) could maintain an updated

list of all ASHAs in the block and would update it as and when changes take place. The list would specify how many families are allotted against each ASHA's name. This would ensure that no family is being left out. The list need only have the ASHAs name, the sub-centre area she comes under, her village and the number of families covered. A more complex list would be as a deterrent against accurate and timely completion. At the district level only the names of ASHAs need be stored.

Though drop-outs are not a significant problem, it is important to be able to decide when an ASHA is to be named as non functional. If states have a monitoring system in place, it would be easy for the district authority to decide this. The state should issue guidelines that declare who is competent to notify an ASHA as "dropped out", after what process of verification, and what process of dialogue is required to get her working again. The exit interview must be recorded. The guidelines should also specify by what process a replacement is selected, trained and deployed.

10. Support, Training and on the Job Mentoring: To implement the monitoring strategy and to provide on the job support to the ASHA, to keep up the pace and quality of training, a support structure within the district is essential. The Financial guidelines/Implementation framework for the ASHA support system, MoHFW, July 2006, laid out clearly the financial norms and the support system needed to support the ASHA. However, implementation of this has been weak in all states, except in Assam and Orissa. In particular emphasis must be given to

    i) Ensuring at least one facilitator for every 20 ASHAs, and a block level coordinator, and a district level team in place.

    ii) Given the expansion of the programme, the district team should include, in addition to the specified, district coordinator and data management assistant at least five full time trainers. In addition there should be a district training team of another fifteen persons, who can spend a considerable part of their time on training. Thus a team of twenty trainers (two per block) for training in current and future modules. This function of training could be outsourced to a suitable NGO where available. The content of the training should address the skill gaps to enable the ASHA to become more functional and effective.

    iii) Clarity on objectives (especially on the seriousness with which we would like the ASHA programme to impact on maternal and child mortality) should drive the skills encompassed in the training content. In the non high focus states the value addition of ASHA to institutional delivery and immunisation rates is minimal and her work may be focused on other RCH indicators, reaching the minority marginalised section which is left out and introducing elements of non communicable diseases or other local priorities as appropriate.

    iv) Every state must have in place an ASHA resource centre or equivalent that would provide:

        a) Overall support and guidance to the ASHA programme.

        b) Serve as the secretariat for the State ASHA mentoring group.

        c) Develop and Manage an ASHA data base, compiling information from the district monitoring structure.

        d) Conduct periodic sample surveys and evaluation studies.

e) Develop state specific communication aids and training material.

f) Build a full time team of state level trainers who would be part of the state training team.

(v) A grievance redressal mechanism, based in every district headquarters, is essential for ASHAs, as recourse for problems with payments and with any other aspect, including lack of support, lack of medicines in the kit, or being unfairly dropped.

11. Synergy in the roles of the ASHA, ANM and AWW:

Based on data from the AWW, ANM, ASHA and beneficiary questionnaire, and our analysis of the strengths and limitations of the ASHA programme, we suggest the following clarifications as regards the AWW and ANM roles in relation to the ASHA's roles and responsibilities. We note that all three actors have overlapping roles. The section below clarifies the main responsibility of each in relation to the other in five major activities at the community level.

Home visits: This is seen as one the ASHA's primary responsibilities. The ASHA will make home visits, prioritising households with a pregnant woman, a newborn (and post natal mother), children under two, a malnourished child and marginalised households. The role of the ANM in home visits is to support the ASHA in making joint visits to the homes of those who do not attend VHND but need ANM delivered services, to post partum mothers, sick newborn and children who need referral services but have been unable to go and those families with whom the ASHA is having difficulty in motivating for changing health seeking behaviours. Though the ANM is expected to make home visits, given her work load she is able to do this only rarely. Using the ASHAs more extensive home visits, and thus selectively prioritising the houses that the ANMs would have to visit, adds value to the tasks of both. The AWW is expected to make home visits only to families where there are children under three with a focus on nutrition counselling and those who do not attend the Anganwadi centre.

Village Health and Nutrition Day: All three play a role here, with the ANM providing the service and the other two playing a supportive role. The ANM provides immunisation, antenatal care, identification of complications, and family planning services. She also provides a supply of IFA tables and oral contraceptives to the ASHA to be dispensed to pregnant and lactating mothers. The AWC (Anganwadi Centre) serves as a venue for the VHND, and hence the AWW is required to enable the support in making this possible. The AWW also provides Take Home Rations to pregnant and lactating mothers and for children under three. Here the role of the ASHA is to mobilise women and children to attend the VHND, through motivation and counselling. This task entails that the ASHA carries out counselling and conveys the key health communication messages as appropriate. The dissemination of such messages could either take place at the VHND or while mobilising mothers and families to attend the VHND. ANMs also are charged with counselling roles, but the time and space they have for contact is inadequate when combined with service delivery, especially in the high focus states.

Village Health and Sanitation Committee Meeting (VHSC): Convening village level meetings of the VHSC or women's groups is the responsibility of the ASHA. The ANM and AWW are expected to play a supportive role

in helping the ASHA conduct the meetings, including the development of village health plans. As part of this task, the ASHA is also required to identify those marginalised sections that are getting left out, and not covered by services in any of the discussed above. The ASHA should take action by reaching out on her own, or enlist the support of the VHSC to improve access to services of these sections.

Escort services to facilities: This is only required of the ASHA. The escort for delivery is incentivised currently at a transactional cost of Rs. 150 (part of the JSY-ASHA package). This is also required for newborn referrals as well. In many other situations where escort becomes necessary, especially for pregnant women and children, it should be encouraged. All escort functions should be incentivised, but voluntary – meaning that the ASHA would be required to provide it only if the family needs the service and if the ASHA's personal circumstance allow for her to go along. Making it mandatory is neither desirable nor feasible.

Record Maintenance: This is a prime function of the ANM and the AWW and should not be passed on to the ASHA. The ASHA does have a diary to record her own activities, but this is only for the purpose of payment and documentation. She also has a register but this is only to enable her to track those in need of services and help her organise her work. The drug stock card is for her use to record her drug supply. The ASHA would not, as a rule have to submit monthly reports and formats. The ANM and AWW should maintain a tracking register and record of service delivery for the services that they deliver.

12. Pari passu with the ASHA programme, states need to revitalise the NGO component of the NRHM to support the ASHA and the VHSC programme. NGO involvement is more or less a pre-condition for the rights aspect of the programme and the mobilisation aspect of the programme to be realised. NGO involvement is also essential to ensure that the process of capacity building and support are more broad based and expand the pool of assistance for the ASHA from such community based organisations.
13. Given the fair proportion of functional Village Health and Sanitation Committees states, should ensure training of VHSC members and building the ASHA's capacity to serve as a key facilitator of the VHSC and village planning process. Convergence with PRI and the AWW and ANM appear to be positive. States should be encouraged to build upon this role by promoting joint training programmes and programme review meetings. No situation should be created where the same financial incentive has to be contested between different health workers, especially when that work has to be done cooperation between all three. Barring such "created" conflicts, the tensions between peripheral health workers are low.
14. There is concern about the long term sustainability of the programme. The experience at five years indicates that if training and support continues, the programme is likely to sustain. International experience also supports this. Criteria for replacement of ASHAs where needed would need to be put in place. Creating opportunities for further career prospects for qualified ASHA in ANM or nurses training courses is another way to encourage a turn-over in a very positive manner. Such prospects can only be enhanced by competency based training leading to certification of all ASHAs over the next three to five years. An approach to long term sustainability could be to divide the tasks of an ASHA as being based on a mix of: some tasks

being done as voluntarism, some regular tasks compensated for by a fixed monthly performance based incentive and some variable tasks reimbursed on a performance based incentive.

15. If however there are pressures to increase their work-load, especially by introducing non communicable diseases, or political pressures to give her an Anganwadi worker like payment and service status, the balance between tasks and incentives must be reconsidered. One of the options would be to expand the service package to make for a six hour work day or to add a second ASHA. We must recognise that even if we were to replace every ASHA with a trained public health nurse or equivalently trained CHW, we would still be well below the international norms for density of 25 skilled health workers per 10,000 population in most parts of India. This point is made to emphasise that the possibility of an ASHA becoming a long term solution is not something to be feared but to be actively planned for.

16. When we undertake long term planning for the sustainability of this programme one dimension we need to keep in mind is the full picture of the ASHA's own expectations, motivations and perceptions of what support she requires as reflected in this study. Monetary compensation is certainly one of the drivers, but not the main one, much less the only driver of this programme. It is clear that despite the scepticism in sections of senior officials and experts, about ASHA's main motivation being community service and despite doubts about programme outcomes and sustainability, the programme enjoys popular political support and the ASHA commands the respect of the community and is driven by her enthusiasm to contribute despite the odds. We need to forge a way forward that builds on the ASHA's own reiterations of community service as being her main motivating element and the concept of voluntarism and activism. At the same time we also need to ensure that we do not become exploitative of her service, and that we respect the need to value her services and compensate her adequately for her time. The challenge is to build institutional structures and organisational strategies that could provide her with the skills and the support needed to ensure her effectiveness in saving lives and promoting health, without losing the spirit of the programme.

"During the Eleventh Five Year Plan, ASHAs will be trained on identified aspects of newborn care during their training. This initiative will be initially implemented in the five high focus States (MP, UP, Orissa, Rajasthan, and Bihar). To supervise and provide onsite training and support to ASHAs, mentor-facilitators will be introduced for effective implementation. The national strategy during the Plan will be to introduce and make available high-quality HBNC services in all districts/areas with an IMR more than 45 per 1000 live births. Apart from performance incentive to ASHAs, an award will be given to ASHAs and village community if no mother–newborn or child death is reported in a year.

11th Five Year Plan document, 3.1.133"

"Efforts to improve home based care have proven successful at improving child survival. Home Based Newborn and Child Care is to be provided by a trained Community Health Worker (such as the ASHA) who guides and supports the mother, family, and TBA in the care of newborn, and attends the newborn at home if she is sick. The worker is supervised by a field person (ANM/LHV or a doctor) who visits the community once in 15 days. Community acceptance and coverage of such care has been quite good.

11th Five Year Plan document, 3.1.131"

"In order to reduce infant and child mortality a continuum of care is needed at the community as well as facility level. Of the two main packages available for reducing child mortality, the HBNC operates at the community level and has a strong evidence of feasibility and reducing child mortality. It should be used to deliver care at home through ASHAs and ANMs. IMNCI training is primarily facility-based and has been shown to improve neonatal care. This will avoid duplication of efforts and, at the same time, provide continuum of care.

11th Five Year Plan document, 3.1.136"

PART II

State Specific Findings and Comparative Case Studies

State Specific Findings and Comparative Case Studies

This section includes state specific findings for key issues related to the Chapter on Policy Framework and Institutional Mechanisms, Comparative Case studies on tbe Selection Process, and on the Functionality-Effectiveness Tables for each of the states. These state specific findings are a consolidation and analysis of the findings from Phases 1 and 2 of the studies, drawing from the individual state reports of the qualitative phase and from the results of the cross sectional survey.

Section 1a: State Specific Findings Related to Management and Monitoring Structures for the ASHA Programme

Assam

In Assam, the State Programme Management Unit (SPMU) takes major responsibility for the programme and is supported by ASHA Resource Centre and the Directorate. The North East Regional Resource Centre (NERRC) provides technical support to SPMU, and participates in decision making. The State ASHA Facilitator reports directly to the Mission Director (MD), NRHM who is the head of the SPMU and Secretary Health. The ASHA Resource Centre (ARC) provides training and district level support. This function has recently, in 2009, been outsourced to a state level NGO, the Don Bosco Institute. The State Institute of Health and Family Welfare (SIHFW) supports the development of IEC material and in conducting trainings. The health minister at the state level and the District Collectors at the district level, take an active interest in the programme, which includes review meetings.

There is a well designed management structure from district to sub block levels to ensure that the ASHA programme is managed effectively and to ensure smooth implementation. In early 2009, Assam (the first of any state to do so) appointed District Community Mobilisers (DCM) and Assistant District Community Mobilisers (ADCM) at the district level to support the ASHA programme. At the block level, the Block Programme Manager, the SDM and HO manage the programme. The DPMs see the DCM and ADCM as taking over some of their workload and also appreciate their contribution in developing the ASHA database. Assam is unique in that it has recruited one ASHA facilitator for ten ASHA. (The guidelines stipulate one per twenty).

The ASHA Facilitators provide handholding support to ASHA at the village level. This includes support in holding Village Health & Sanitation Committee (VHSC) meetings, counselling families who require additional inputs for behaviour change, helping her during immunisation and ANC sessions, and accompanying while visiting newborns, as well as updating their knowledge and skills for improved performance.

The DCMs have to spend a lot of time at the District headquarters and are not yet able to provide much support to the block level programme, other than reporting and organising trainings. This reflects the volume of work at this level and officials at district and block levels, expressed the need for a team at the district level, who would also help the DCM to carry out tasks in the blocks. The ASHA Facilitators provide handholding support to ASHA at the village level and this includes support in holding Village Health & Sanitation Committee (VHSC) meetings, counselling families who require additional inputs for behaviour change, helping her during immunisation and ANC sessions, and accompanying while visiting newborns, as well as updating their knowledge and skills for improved performance. All the ASHA facilitators are women and some of them have also worked as ASHA or as health workers in the Mother NGO programme. They have been trained for three days on their role as facilitators, but have not yet been trained in the contents of the ASHA modules.

Before the ASHA Facilitators, it was the ANM who saw herself as being responsible for the ASHA. Even now she exercises some authority over the ASHAs and ASHA Facilitator. There are weekly meetings between the ASHA Facilitator, ANM and ASHAs. All of the respondents appreciated the appointment of ASHA Facilitator, though one Block medical officer expressed the view that health department staff is better suited to support the ASHAs. They also saw the facilitator as a link between ASHA and block health system and another helping hand for the ANM. In some of the blocks facilitators have to fill detailed formats regarding immunisation and other services at Village Health & Nutrition Day. They have been doing parallel reporting. Most of the interactions of facilitators with ASHA seem to occur in the presence of ANMs. The Block Programme Managers (BPMs – a contractual cadre under NRHM) also provide support to the ASHAs in resolving issues at the field level. ASHAs appear better supported where the support structure (DPM, SDM and HO, BPM) consists of women, as evident in Dibrugarh.

A number of efforts have been made to make things convenient for the ASHA. A system of feedback has been introduced through the ASHA Post Cards. A post card with the printed address of the Radio station is given to all the ASHA. They are encouraged to comment or ask questions on the topics discussed on the ASHA talk show via the post card. The radio station with support from the department conducts a quarterly review of the questions posed by the ASHA, answered in a subsequent talk show. The various complaints/queries have been compiled into reports which very candidly note various instances of corruption and bad behaviour on part of health staff.

The ASHA Mentoring Group (AMG) was set up in Assam and consists of ten members including the senior government officials, NGO representatives, and eminent individuals. Two meetings have been held till date. Each member is responsible for mentoring one district. The AMG was perceived by state officials as having the expertise and organisational backing to provide inputs to the programme including conducting research studies, orientation and training. The national guidelines serve as a broad framework, but they are reviewed for appropriateness to local context and modified accordingly.

Orissa

The Community Processes Resource Centre (equivalent of the ASHA Resource Centre in other states), provides implementation support from the state level,

with substantial support from the Mission Director. This centre has a five member team to oversee the community processes programme. This team develops progress reports based upon frequent interactions with district and block teams and periodic field reviews. They are also responsible for developing operational guidelines and resource material.

At the District level a District ASHA Coordinator, has been appointed under NRHM to coordinate the ASHA and VHSC programmes. He/she is supported by the District Programme Manager, (DPM – in charge of all NRHM activities), a District Health Information Officer (DHIO). They are supported by the Chief District Medical officer. At the block level, the Block Programme Officer, another full time contractual employee under NRHM, supervises the ASHA and Gaon Kalyan Samiti (GKS, equivalent to the VHSC in other states). He is supported by a Block Accounts and Data Assistant. Two block officials are nominated as Sector in-charges and they are responsible for conducting sector meetings, payment of incentives, drug kit replenishment, and operational decisions as well as problem solving. (sector is a sub-block unit of about 30,000 population) At the field level, the ANMs provide handholding support to the ASHA.

The ASHA programme in Orissa has a well established, elaborate and structured set of review meetings to ensure monitoring at each level. There are bi weekly meetings at the village level, monthly certification of ASHA's work by the ANM, review meetings at the sector level, monthly Block ASHA Diwas and quarterly District ASHA Diwas.

The ASHA programme in Orissa has a well established, elaborate and structured set of review meetings to ensure monitoring at each level. There are bi weekly meetings at the village level, monthly certification of ASHA's work by the ANM, review meetings at the sector level, monthly Block ASHA Diwas, and quarterly District ASHA Diwas. The latter two are designated as days for review of the ASHA and community processes programmes.

At the village level, the ASHA has support from the AWW/ANM but since the last one and half years, the VHSC also provides support. In the VHSC, all the important stake holders in the village are represented and they are the decision making body in the village. Although the ASHA Mentoring Group was established early on, few meetings have been held so far.

Kerala

The ASHA programme is implemented and monitored through existing institutional structures established for the NRHM at all levels. At the state level the Mission Director heads the Mission, with the State Programme Manager (who is also the Additional Director, Health Services and Executive Director, of the newly constituted State Health Systems Resource Centre, SHSRC) heading the State Programme Management Unit (SPMU). No separate structures exist for the ASHA programme, although the SHSRC has a team of three consultants to support the ASHA programme. Their roles in the programme although defined as support to the ASHA programme are still fledgling, since programme experience is located with the SPMU and there has been little transfer of responsibilities or active linkages to date.

At the district and block levels, the District and Block Programme Managers, respectively, set up for NRHM management, provide oversight of the ASHA programme. At the sub block level, the Junior Public Health Nurses and the Junior Health Inspectors are actively involved in the management of the programme. The PRI play an important role in the management of the programme from selection to monitoring. At the village level the ASHA programme is supported by the women's committees, (such as groups in the

Kudumbashree programme), Ward Health and Sanitation Committee of the Gram Panchayat, and the peripheral health workers. At the Gram Panchayat level ASHAs are supported by a co-ordination Committee with the PHC Medical Officer as Convener and Gram Panchayat President as Chairperson. All ASHAs are involved in this Ward Health and Sanitation Committee as members.

The ASHA programme appears to be entirely government managed with little involvement of civil society organisations. The state has not set up a State ASHA Mentoring Group.

Rajasthan

The management of the ASHA programme is located within the State Programme Management Unit (SPMU) and managed by a State ASHA consultant. Early in the programme, the overall coordination of the ASHA programme was entrusted to the State Adult Education Bureau. In 2007, this was moved to the State Institute of Health and Family Welfare (SIHFW). Now the state has constituted a State ASHA Resource Centre located within the State Health Resource Centre provides policy guidance and programmatic oversight at the state level. It has yet to make a credible space for itself in the programme.

Major decisions such as NGO involvement, training schedules, and training content are discussed in meetings of the State ASHA Resource Centre with the Principal Secretary (HFW), MD (NRHM), RCH Project Director and the State ASHA consultant participating. These decisions are communicated to the District Health Society. District ASHA Coordinators (DAC) and Block ASHA Facilitators (BAF) are expected to implement the programme at district and block levels. At the Sector PHC level, the state has appointed PHC – ASHA Supervisors (in lieu of ASHA facilitators). The main roles of the DAC and BAF include developing training plans, ensuring timely payment of incentives, coordinating with NGOs, PRIs and other stake holders, conducting review meetings at district block and PHC level, and timely submission of monthly progress and financial reports. There is little time for field monitoring.

It appears that the coordination mechanism between ARC, directorate and the SIHFW is weak and fluctuates with the nature of administrative leadership. Layers of supervisors and facilitators have been added in the system with little role clarity, training or support.

Issues at the district level are communicated to the State ASHA consultant who negotiates with the District Magistrate or the CMHO to resolve issues. Staff shortages at the district level often lead to the DAC getting involved in other activities leaving them little time for the ASHA programme. They are also expected to be supported by the District Programme manager in carrying out their duties. In Banswara this appears to work because of a committed DPM, but in Bundi, the Medical Officer of a CHC doubled up as a DPM. The DAC in both districts said that district level meetings chaired by the District Magistrate or the Additional District Magistrate are irregular and this delays decisions leading to programmatic interruptions and tardy implementation.

During individual discussions, it appears that the coordination mechanism between ARC, directorate and the SIHFW is weak and fluctuates with the nature of administrative leadership. Layers of supervisors and facilitators have been added in the system with little role clarity, training or support. The criteria for selection of facilitators were reduced to grade assessment during graduation and not on the basis of their overall suitability for the job.

Innovative district administrators seem to have played a major role in activating district level activities in Bundi, taking interest in the security and welfare of the ASHA (providing them waiting rooms at the district hospital, appointing ombudsmen for examining grievances, and motivating sarpanches for formation of the VHSC). Other support systems in Rajasthan include the use of media (largely radio and local newspapers) in advertising the role of the ASHA, the initiation of state and district level awards, exposure trips and the publication of a newsletter for the ASHA in the state. While media campaigns and the role of the ASHA have the potential for a powerful advocacy effort, they need systemic and innovative expansion.

The State ASHA Mentoring Group in Rajasthan was established in 2006 and was expected to meet on a quarterly basis. Only two meetings were held until early 2010. The state has recently reconstituted the group, which has met once. NGO involvement in the ASHA programme is limited to training.

Andhra Pradesh

The entire management of the ASHA programme is done by existing department staff as an additional task to their current assignments. The MD NRHM (Commissionerate of Family Welfare) heads the ASHA programme in the state. The Joint Director (NRHM) is in charge of looking after the logistics, budget and the training support at the state level.

The Programme Officer, District Training Team (PO-DTT), is in charge of overall supervision, training and recruitment of ASHAs in the district, with the District Programme Officer (DPO) looking after overall NRHM activities at the district level. The District Public Health and Nutrition Officer (DPHNO) is the nodal officer for ASHA at the district level who is in regular touch with ASHAs and PHCs. Since most DPHNOs were involved in the initial training process, the quality of their support is good-but they have to handle this work in addition to their other functions. At the PHC level Lady Health Visitor (LHV) is the ASHA Nodal officer. In some cases, a Public Health Nurse at the PHC level also serves as the nodal person. Currently ANM is the only person to provide day to day hand holding to the ASHA with some support from the PHC doctor. There is no ASHA resource centre or State ASHA Mentoring group.

The DPHNO submits a monthly report and the District Health Society conducts a six monthly review of the programme. The Monthly ASHA day is also helping in better monitoring especially on getting ASHA incentives though not on time. District Health Societies only play a role in fund flow management. Some block level officials felt that the ASHAs feel self-motivated to run the programme despite lack of support from the district and state level.

No State ASHA Mentoring Group has been set up. No NGOs are involved in programme implementation. The need for a State ASHA Resource Centre and support structures at district and block levels was expressed by state officials.

West Bengal

At the state level, the programme is being implemented by the Department of Health and Family Welfare under the overall guidance of the Mission Director (NRHM) and Joint Secretary (NRHM). Till now programme management has

The District Public Health and Nutrition Officer (DPHNO) is the nodal officer for ASHA at the district level who is in regular touch with ASHAs and PHCs. Since most DPHNOs were involved in the initial training process, the quality of their support is good-but they have to handle this work in addition to their other functions.

meant managing recruitment, training and incentives, and so the roles for the programme management and supervision are defined in terms of selection, training and incentives. The District Health Samiti (DHS) is the formal authority approving ASHA selection and overseeing training. The DHS is also responsible for reviewing the ASHA implementation process at regular intervals and take necessary actions for better implementation. But in practice, the District Programme Coordinator and the NGOs manage most of the work. The Block Medical Officer is overall in-charge at the block level, with support from Block Accounts Manager and Block PHN (nodal person). They together, along with the Sabhapati of the block Panchayat, constitute the Block Health Samiti, which is the body responsible for finalising selection of ASHA, disbursement of compensation, and overseeing the training of ASHA.

The ownership of the programme at the field level is with the Gram Panchayat (GP). The GP is responsible for advertising the post, recruitment/selection, and monitoring through monthly meeting. The ANM who is on the interview board at the GP level, is responsible for ensuring attendance at weekly meetings, at VHNDs and certifying the work of the ASHA to enable compensation from the BMOH/block. They are expected to gather information about health events from the ASHA, but the roles in supervising or otherwise supporting or training ASHA on the job are not clearly spelt out or perceived as necessary by the ANMs.

There is no state ASHA Mentoring Group. Child in Need Institute (CINI) with the support of the MNGOs that already existed under RCH is the nodal agency for ASHA training. For the first year after ASHA training the trainers provided support to the ASHA. Support systems have not yet been thought through. State officials as well as CINI and MNGOs believe that there is need for a support structure beyond the first year.

At the district level, Civil Surgeons lead the programme. The state has very recently recruited District Community Mobilisers, District Data Assistants and Block Community Mobilisers. The Medical Officer in Charge (MOIC) of the Block PHC manages the programme at the block level.

Bihar

The Executive Director (ED) of the State Health Society leads all NRHM programmes including ASHA at the state level. The Project Manager (ASHA) is a key position at the state level, created specifically to oversee programmatic, financial and administrative functions of the ASHA programme. Currently, a senior medical doctor with experience in managing disease control programmes is posted in this role. The Project Manager (ASHA) is supported by Deputy Project Manager (ASHA). The Project Manager prepares the drafts of guidelines which are then approved by the ED.

The state is in the process of setting up an ASHA Resource Centre. PRANJAL, a training institution set up by Public Health Engineering Department has been given the responsibility to carry out the training activity for ASHA programme and also sees itself as the implementer of programme. This institution is headed by an engineer – and there is no experience in both community work or in the health sector within the organisation.

At the district level, Civil Surgeons lead the programme. The state has very recently recruited District Community Mobilisers, District Data Assistants and Block Community Mobilisers. The District Programme Managers (DPMs) play the key role which mainly consists of transferring funds and guidelines to the blocks and monitoring fund utilisation. The Medical Officer in Charge

(MOIC) of the Block PHC manages the programme at the block level. They have significant involvement in the programme activities and interact often with ASHAs. The Block Health Managers (BHM) carry out the day to day tasks with help of the block accountant. ANMs also interact with the ASHAs in the field on a frequent basis.

The state also has a State ASHA Mentoring Group, which has met infrequently. Monthly ASHA Diwas take place at the PHC level and serve as review meetings at that level.

Jharkhand

The Mission Director (MD), NRHM, leads the implementation of the Sahiyya programme at the state level[13]. Prior to the launch of the NRHM, the Government of Jharkhand entered into a Memorandum of Understanding (MoU) with an NGO, Child In Need Institute (CINI) to develop the operational guidelines and training modules for the programme, and provide technical support for the selection and training of Sahiyyas. CINI set up the Sahiyya Working Group (SWG) in partnership with two other NGOs. The SWG started programme implementation in 35 blocks in partnership with NGOs. In 2009, the state created the Village Sahiyya Resource Centre (VSRC), which is state led and subsumed the functions of the SWG, but included the representation of all three organisations. The VSRC is part of the Jharkhand State Health Resource Centre, (JHSRC). The VSRC is intended to focus on training strategies and structures, development of support and review systems, streamline incentive payments and supplies and identify and address bottlenecks in implementation. At the District level, the Sahiyya programme is expected to be implemented under the leadership of the Civil Surgeon (CS), and support systems for the Sahiyya programme are still evolving.

The state has recruited and posted a District Programme Co-ordinator (DPC) in 22 districts to coordinate and support the Sahiyya programme exclusively. The Mission Director plans for a Block Programme Manager to undertake block coordination of the Sahiyya programme in addition to other NRHM coordination. Within the block, the VSRC is planning to develop a 10 member support structure that will provide field based training and support to Sahiyyas.

In the first phase of expansion the programme was contracted out to NGOs. However after two years the state withdrew from this. Support to NGOs was weak, and payments were irregular. There were allegations about some of them. NGO run Sahiyya programmes in selected areas have tried to evolve self supporting mechanisms for the Sahiyya. In West Singhbhum, the NGO representative stated that they had facilitated the selection of block level leaders from amongst the Sahiyyas and encouraged them to voluntarily meet once a month to support each other and address their problems. This group reported meeting the district collector to resolve some of their issues.

PHCs organise monthly meetings of the Sahiyyas and Medical Officers, but these meetings are used for the distribution of incentives and are often led by the Accounts Manager. The meetings are poorly attended by Sahiyya in some districts given the distances and the expenses of travel.

13 A team comprising of the State Reproductive and Child Health (RCH) Officer, State Programme Manager, NRHM, State NGO Coordinator, National Health Systems Resource Centre (NHSRC) State Facilitator and the VHC-Sahiyya Resource Centre (VSRC), support the MD, NRHM in implementation.

Section 1b: Political and Administrative Leadership of the Programme

Assam

The state leadership is very conscious of the contributions of the ASHA and has identified several avenues to build solidarity among the ASHA, enable feedback and be responsive to the views of ASHA, sustain their motivation, create incentives for better performance, and enable smooth functioning.

The ASHA programme in Assam is characterised by stability in leadership and the team at the State level and in the agency for technical support. The senior leadership, i.e., the Mission Director and the State Programme Manager have been in place since 2006. In addition the ASHA programme commands substantial political support from a Health Minister also in place since the launch of the NRHM. His interactions with the ASHA are frequent and he provides a well informed and enthusiastic leadership for the programme. His recent interventions include the provision of bicycles to the ASHA with state funds. Two major state level rallies with mobilisation of ASHA from across the state, sent down a strong signal regarding the priority of the political leadership in making a success of the ASHA programme. The state leadership is very conscious of the contributions of the ASHA and has identified several avenues to build solidarity among the ASHA, enable feedback and be responsive to the views of ASHA, sustain their motivation, create incentives for better performance, and enable smooth functioning. Another indicator of commitment has been the readiness of the state to ensure that operational guidelines related to support structure for the ASHA were put in place. Leadership and commitment are high at district level as well.

Orissa

Several programmatic initiatives confirm the sensitivity of state level functionaries to the needs of ASHAs as central stakeholders in the programme. The Mission Director expressed this with the sentiment that he wished ASHAs to feel that "The government, the system, thinks about us".

The study team noted that "one of the most notable observations was the political will and capability demonstrated by key state level decision makers". Major policy decisions are referred to the Minister and Secretary of Health. The minister had on several occasions participated in key programmes and expressed active support to the programme. The Mission Director noted that to date both have been supportive of every change proposed. Several programmatic initiatives confirm the sensitivity of state level functionaries to the needs of ASHAs as central stakeholders in the programme. The Mission Director expressed this with the sentiment that he wished ASHAs to feel that "The government, the system, thinks about us". A striking example of this has been the clearing of a backlog of incentive payments to the ASHA of nearly Rs. 7,60,00,000 on one day in September 2009. Other aspects of this commitment are reflected in the institution of motivating instruments for the ASHA such as: annual awards, establishment of ASHA Gruhas at the facilities so that ASHA are motivated to escort patients from their villages, promote payment of incentives, provision of umbrellas and torches, uniforms and bicycles. This strong and stable leadership at the state levels has translated into positive policy decisions becoming institutionalised by the field cadres and good systems of monitoring and review.

Kerala

The decision to scale up the programme was taken by the political leadership, backed by the administration. The rationale for this decision was described by state officials as the need for a locally selected, and therefore culturally more acceptable community level worker to address preventive and promotive

behaviours at the home and, family and community level, given the increasing incidence of non communicable and to address the issue of immunisation dropouts and relatively lower service coverage indicators in marginalised areas. State officials also said that the ASHA programme afforded them an opportunity to ensure high quality training, support and performance based incentive form of payment. Poor consideration of these three factors were perceived as being the cause of failure of past community worker interventions. However beyond this, there appears to be little other demonstration of political or administrative commitment in further developing and strengthening the ASHA programme to focus on outcomes. A technically competent plan to convert political will into do-ables that yield positive visible health outcomes in the Kerala context seem to be the challenge.

Rajasthan

Directorate officials and programme managers stated that frequent changes in the Mission leadership hampered programme implementation. Political support is also not as visible as in other states. Management issues arising from double ownership between the Department of Health and the Integrated Child Development Services (which runs the Anganwadi Centres) also created conflict, with the ANM and AWW claiming first right on the ASHA and pressurising her to prioritise "their tasks". Thus the ASHA is dominated by ANM at the PHCs and AWW at the Anganwadi and during Village Health and Sanitation Committee meetings. She is expected to undertake multiple tasks, which are not her primary responsibility. Her double payments through both the departments render her vulnerable in the lowest hierarchy of workers of both the departments. The health system expects her to meet multiple targets without consistent referral support and without an appropriate training base. The team observed that an important reason for better performance in Bundi is the presence of adequate number of doctors and other health personnel for providing referral services to the ASHA and at least an attempt to upgrade infrastructural facilities. In contrast, Banswara seemed to have poor infrastructural facilities and a dearth or constant movement of doctors at the PHC level.

West Bengal

This programme has formal political support, but this is not visible in the form of management structures or pace of the programme. There is stability in most of the key senior and mid level positions at the programme level. However, changes in the political leadership at the Panchayat level after the Panchayat elections in 2008, has led to delays in recruitment processes in Gram Panchayats (GPs) where a new party came to power and objected to the ASHA "list" approved, but not yet appointed by the previous regime. Concerns that ASHA selection might be influenced by party loyalties at the village level and mechanisms to prevent it may have bureaucratised the selection process and reduced community participation. Actual ASHA programme management (other than selection, training and compensation) is yet to be fully conceptualised in the state.

Andhra Pradesh

There has been stability at the level of the senior leadership, with strong bureaucratic commitment from the state level being driven downward to

district and block level. Political commitment is neither articulated nor visible, but there is no reluctance either. The NRHM leadership works in convergence with departments such as tribal department, the Society for Eradication of Rural Poverty (SERP), Women and Child Welfare and Health Directorate. In some cases task force committees are set up to resolve field level issues and financial matters. About 70% of the "community health activists" of the SERP were selected as ASHA.

The entire training component has been outsourced to a relatively inexperienced PHED department. There is visible political support for the programme, but has not translated into better governance.

Bihar

Frequent leadership changes at the state level was cited one of the reasons for long gaps in ASHA training and delay in payments of ASHA incentives by the district and block level teams. The state has had about 14 Mission Directors since the start of the NRHM. The State Health Society was slow in creating even the basic management structures for programme operationalisation. The entire training component has been outsourced to a relatively inexperienced PHED department. There is visible political support for the programme, but has not translated into better governance.

Jharkhand

The Sahiyya programme was launched in 2003–2004 by the Health minister, with operational guidelines released by the Chief Minister, and the state established institutional mechanisms for smooth implementation, and actively involved NGOs in the programme. Despite all this, frequent changes in political and consequent senior bureaucratic leadership, have adversely affected the pace and quality of the programme. For most of this programme period the political leadership had been indifferent to the programme. Since the Sahiyya programme was first announced in Jharkhand in 2003–04, the state has had 6 Chief Ministers, including President's rule for a year. The Secretary, Health has been changed 6 times and the Mission Director thrice. Two health secretaries have been charged with irregularities. The impact of these constant leadership changes and weak leadership on the design and implementation of the Sahiyya resulted in modifications in programme guidelines and implementation structures some of which altered the very nature of the programme and squandered an excellent civil society support and good will that was available.

Section 1c: Training Curriculum and Training Strategies

Assam

Assam has recently selected Don Bosco Institute as the ASHA Resource Centre in the month of February 2009. This is seen to be a permanent training structure, development of training materials and also maintaining a training data base.

For the first four rounds of training, a group of state trainers, trained in NIHFW, trained District Training Teams comprising of personnel from the health system, Zilla Parishad and NGOs. They then trained the Block Training Team which also had representation from grassroots functionaries of the health, ICDS, PRI

departments, and NGOs. State level ToT for Module 5 for Assam was conducted by Chetna, a Gujarat based NGO. The national training modules were translated into Assamese, Hindi, Bengali and Bodo. The State and Districts did not start the training till the translated modules were available, even though this led to delays in training All the ASHAs had copies of the books. The 5th round had pre test and post tests in order to monitor the training quality. Tracking of training was being done through the data sent from the block to the state.

The impression of NGO performance in the training programme is mixed. There is also a gender imbalance among the trainers, even for the fifth round. For example, in Karimgunj district, there was only one woman out of 20 trainers. The method for training is only lectures and a number of officials did realise that this needs to change to more participatory methods. Other than the formal trainings, the ANMs were imparting information to the ASHAs on a regular basis, on new schemes. The SDM and HO also undertake training the ASHA when they come for meeting.

The sample survey of phase II shows that 64% of ASHAs in Assam have completed round 5 and 90% have completed four rounds. Only 21% have less than 16 days training. Most have had over 16 days of training. 87% of ASHAs from Karimganj reported receiving more than 16 days while this was 67% in Dibrugarh. Of these 27% had received more than 23 days (Table 5). A large number of ASHAs stated a preference for non residential training and often training had been non residential.

The sample survey of phase II shows that 64% of ASHAs in Assam have completed round 5 and 90% have completed four rounds. Only 21% have less than 16 days training.

Over 85% of ASHAs recollected the following topics as having been covered Immunisation, JSY, maternal and newborn health and family planning. Much less ASHAs-about 50 to 70% – recollected being instructed on illness management in children, water and sanitation issues, malaria, nutrition issues, first aid and general aspect of NRHM. Only 20 to 40% remembered being instructed on AYUSH and home remedies. Knowledge levels as tested reflected this-and even within the RCH topics only the most central messages and intuitive messages had got through. Relatively less step up had happened as compared to other states.

Orissa

The Community Processes Resource Centre (CPRC) is responsible for the development/adaptation of the training modules and training strategy in the state. A majority of ASHAs have completed the fourth round of training, and in some districts, the fifth round is also complete. Additional training in First Aid has taken place in 13 districts and Post-Natal Care training funded by the Norway India Partnership Initiative (NIPI) in three pilot districts. Up to the 4th Round, the trainings had been conducted internally by AYUSH, ICDS functionaries, and Medical Officers. However, since the 5th Module NGOs have been involved to improve quality and reduce pressures upon existing staff. To minimise the transmission loss of the cascade model training the state has eliminated two levels of training. This is now the pattern: Training of State training teams – Regional level of training of ASHA trainers – Training of ASHAs. For each of the training rounds a residential approach was adopted, the first module being a 5 day course and the rest have been 4 days each. Many respondents stressed the need for periodic refresher trainings to maintain standards of competency, as well as ensuring the ASHA is professionally

supported in her work. To date the training modules used were those that had been provided by central government, but translated into Oriya by CPRC. The state plans to develop state specific training modules which will be shorter but more frequent.

75% of ASHAs in Orissa have completed round 5 and 82% have completed round 4. Nearly 93% of ASHAs from Angul reported receiving more than 16 days training of as compared to 78% from Nayagarh. However 69% of ASHAs from Nayagarh have been trained for more than 23 days while the corresponding figure was 37% in Angul.

75% of ASHAs in Orissa have completed round 5 and 82% have completed round 4. This seems to be because of weaker attendance in Nayagarh, for in Angul almost 100% have completed round 5. Nearly 93% of ASHAs from Angul reported receiving more than 16 days training of as compared to 78% from Nayagarh. However 69% of ASHAs from Nayagarh have been trained for more than 23 days while the corresponding figure was 37% in Angul.

In terms of content of training, except for AYUSH, animal bites and some aspects of first aid-in all else recollection was over 85%. Even in these elements it was 50 to 70% which is substantially better performance than the other states.

Kerala

Training was initiated in 2007, with National training of six state level trainers, and adaptation of the national Module-1 to Malayalam. 168 trainers from all districts were trained in three regional ToTs. The district teams trained 560 people from the block levels, and a one day orientation of health officials of various levels. A seven day induction training of ASHAs was held at the district levels. The overall progress of the programme appears slow. One reason is that the training of ASHAs is centralised at the district level and this limits the numbers that can be held concurrently, although it has added to the quality. ASHA Module-2: was modified with communicable and lifestyle diseases (Cancer, stroke, CVD, spinal injuries, epilepsy, mental retardation, palliative care, and mental health) covered in detail. ASHAs have been provided with three flipcharts and health education material. However, there is no system to monitor how and when the material is used by the ASHAs.

In terms of rounds of training, 100% have received three rounds of training and 53% have received four rounds and in terms of days, 53% reported receiving training over 16 days. Over 90% of ASHAs were able to recollect every key topic as being covered-plus substantial inputs in Non communicable diseases- the best figures for any state. This was because all the information in the four modules had been reorganised into three rounds.

Rajasthan

In terms of rounds of training, 100% have received three rounds of training and 53% have received four rounds and in terms of days, 53% reported receiving training over 16 days in Kerala.

The State ASHA Resource Centre is now responsible for training of ASHA Sahayoginis. State level trainers were selected and deployed for each round of training, but because of long gaps and limited engagement, they dropped out of the programme. The district training team included representatives from NGOs, the health department and the ICDS. Since the ASHA Sahayoginis were already conversant with some aspects of health and nutrition, the modules were modified. The first round of training was spread over ten days, (topics included awareness on hygiene, MCH, and HIV). The second phase of four days included topics such as Family Planning, and Immunisation. Additional training has been given on Integrated Management of Newborn and Childhood Illness (IMNCI) (8 districts), and on H1N1 flu, TB, leprosy and preparation of malaria slides and testing for pregnancy during monthly sectoral meetings.

NGOs have brought in innovations in training methodology and material and have attempted to ensure that knowledge of ASHA meets a basic standard. It appears that the state has been slow to recognise this potential and continues to treat NGOs as logistics and operations managers. Once the training was over, there was no contact between the ASHA and NGO trainers. NGO's felt that post-training interaction and mentoring would be beneficial in terms of interim hands on training and revision of previous training. In districts such as Banswara, Bundi, Baran, Churu and a few others, modules have not reached all ASHA. The training at Bundi appeared systematic and more content focused than that at Banswara though medical officers at both locations expressed the need for further training and refreshers.

About 42% had completed 4 rounds of training and 80% had completed 3 rounds of training. In Bundi as high as 90% of ASHAs received more than 16 days of trainings, of which 40% received more than 23 days of training? (Table 5). Training was much slower in Banswara, where about only 47% reported being trained for more than 16 days. Again the number of rounds of training is misleading because the four rounds of training had been compressed into three rounds, with some more addition from the ICDS-nutrition angle. Thus the actual training was a ten day ICDS module, plus eight days for the first modules plus four day training for modules two to four. As in Assam, about 80 to 90% recollected key messages in maternal health, immunisation, JSY and some aspects of newborn care, only 50% to 70% recollected learning disease control, family planning, water and sanitation and first aid and less than 40% recollected learning anything on drug kit, AYUSH, NRHM introduction and home remedies.

About 42% had completed 4 rounds of training and 80% had completed 3 rounds of training. In Bundi as high as 90% of ASHAs received more than 16 days of trainings, of which 40% received more than 23 days of training.

Andhra Pradesh

The government identified an NGO, the Academy of Nursing Sciences, (ANS) for module development and ASHA training. Training was focused on empowerment and had an activist and facilitator understanding. ANS completed the training in 18 months in all the 22 districts.

Convergence and clear allocation of responsibilities between three departments-department of Child and Women Welfare (CWF), Women's Finance Corporation (WFC) and Department of Family Welfare, and the ANS enabled the smooth implementation of the training programme at the district level. ANS managed the production of training material, training of trainers and administrators and the organisation in each district by a District Training Administrator (DTA) who was employed by ANS full time. The Department of Child and Women's Welfare took care of nomination, field linkages and liaison with health department. ANS appointed a District Training Manager (DTM) who was a full time employee of the CWF, deputed full time to ANS for ASHA training work. WFC took care of food, stay, logistics support and training equipment through a specially appointed District Manager.

ANS also recruited from every district, two training coordinators (who are technical people) to implement the training programme. The DTM was a nodal person between the government departments and ANS to supervise ASHA's training and incentive matters. ANS recruited a full time team of 5 public health nurses in each district with an 18 month contract to coordinate the training. The government filled the vacancies of DPHNOs in 22 districts,

to increase government ownership for the programme. A team of full time trainers at state and district levels, adequately compensated, with an assured 18 month contract, ensured 30 days of residential training for ASHA until all 70,700 ASHAs were trained.

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All training material was prepared by ANS and stakeholders felt that the quality of residential training helped in keeping the dropouts low. The mechanisms used according to the ANS have helped in connecting ASHAs with the functioning of Sub Centre and the PHC before the placement. The 30 day training was completed in the state at a stretch. The state is now planning for refresher training, and to introduce new topics. A core committee has been setup to coordinate all issues for training at the district level. The state level core committee will comprise of NGOs, such as ANS, training officers of the district and DPHNOs.

The state was unable to use the national modules since the programme was half way through implementation when NRHM was launched. The module covers general information about the health status in the country and the state, adolescent health, pregnancy, newborn child, family planning, HIV, communicable diseases, and little information about the medicines are the specific topics covered. The focus is more on the preventive rather than the curative aspect. Even on preventive issues the focus is on health awareness. There appears to be a mismatch between the programme design and expectation from ASHA. The ANS leadership was clearly focused on a rights based approach, with consideration of measurable outcomes being secondary.

Overall about 78% of ASHAs have been trained for more than 16 days and out of these 32% got up to 30 days of training. (Table 5) Only 14% recollected having learnt anything on AYUSH during the training programme, but in management of bites, first aid, drug kit, and common child hood illness about 60% to 80% recollected learning these, while nearly 90% recollected learning RCH topics including RTI/STI aspects during the training programme.

West Bengal

West Bengal has identified the Child in Need Institute, as the state nodal agency, and leveraged the existing network of RCH MNGOs to create a short cascading structure (two-tier: master trainers, co-facilitators), and strict monitoring to ensure that five rounds were completed within one year.

The state has identified the Child in Need Institute (CINI), as the state nodal agency, and leveraged the existing network of RCH MNGOs to create a short cascading structure (two-tier: master trainers, co-facilitators), and strict monitoring to ensure that five rounds were completed within one year. All ASHA trainings were residential at MNGO sites, and this had wide acceptance. ASHAs are trained in five rounds with coordinators to oversee and facilitate the training. These two cadres are directly trained by CINI at Kolkata for a total of 12 days.

Apart from CINI (and the MNGOs), no other institution is involved in the creation or adaptation of training materials, or actual training at any level. CINI's master trainers monitor training quality by being physically present for at least 6 of the 23 days of the ASHA training, but this support is much less intense now than during training in the first two phases of blocks. CINI's explanation was that their team finds it difficult to manage quality monitoring with increasing training load. Funding for covering such large areas spread out across many districts was also expressed as a constraint. The trade off is that the programme was limited by the level of current management capacity: limited to less than one third of the blocks.

Significant changes to the national modules have been made with regard to content and sequencing. In Module five, the content on health rights has been reinterpreted as 'entitlements to health schemes' since it was considered too complex to deal with rights so early in the ASHAs training.

Almost 100% had received training upto Round 5 in 5 distinct rounds and almost all had also received over 23 days of training. Most remembered RCH topics being taught, and about 30% did not recollect AYUSH or the drug kit being taught. Other topics ranged in between, for example 65% recollected learning care in childhood illness.

Bihar

Initially the SIHFW was involved in the training, but then the training was outsourced to PRANJAL. The centrally designed modules were used for the training. ASHA was trained in Module 1 over seven days. Modules 2, 3, and 4 were clubbed into a 12-day training. It was rolled out through state and district ToT and ASHA training at the block level, with involvement of NGOS for logistics management. ASHAs are trained in non-residential batches of 35 each. In some places at the district level, MOs trained ANMs who in turn trained ASHAs. ANMs or LHVS provided most of the training without participating in the ToT. The guidelines for Trainer selection were developed by PRANJAL.

In the first round, the state used the national Module 1. For the 2nd round (national modules 2, 3, 4 combined), a book and pictorial version, and a training guideline has been developed. UNICEF had helped in incorporating Muskan Abhiyan, the campaign on child immunisation into the module.

Officials at all levels perceived that the actual training on the ground was of poor quality. Overall about 87% of ASHAs have received less than ten days of training, over a four year period in Bihar.

PRANJAL provides a list of trained ASHAs but there is no mechanism to verify numbers or quality of training. Officials at all levels perceived that the actual training on the ground was of poor quality. Trainings in the districts visited were also conducted by MOs, BEEs, LHVs, ANMs or CDPOs. The majority view in the health department is that outsourcing has not been useful while staff at PRANJAL feel that the department has no capacity to undertake trainings. State and district level informants agree that an institutional mechanism is required to improve the quality of the training. Members of the state and district level team feel that guidelines prepared by PRANJAL were of poor quality. They feel that a permanent structure of state and district level training teams may be needed. Thirty districts have completed Round 2 of the training.

In Bihar rounds 2 to 5 were combined as only 20% of the sample had covered these classes. Almost 100% though had completed the first round. Overall about 87% of ASHAs have received less than ten days of training, over a four year period. What they recollected learning was inconsistent with this-though many topics in Module 1 such as introduction to NRHM and government services were recollected by less than 12% and nutrition topics by nearly 40% – while management of common illness could be recollected by 52% and first aid by 86% !!

Jharkhand

Sahiyya training upto Module 4 was conducted by 21 NGOs across the state in the specific blocks assigned to them. For the training, each NGO was expected to appoint 10 facilitators per block to conduct camp based training of the

Sahiyya as well provide continuous support. A training of trainers (TOT) was conducted at the state level, with a second tier of training of block trainers who trained the Sahiyyas. At the state level, nearly all officials interviewed felt that the quality of training provided by NGOs was questionable.

As of December 2009, the VSRC had developed the module on Sahiyya Leadership, Village Planning as well as a flipbook of key messages that the Sahiyya is expected to communicate. A handbook describing the Sahiyya programme has also been developed. The process of module development was coordinated by the Sahiyya Working Group previously and currently VSRC but involved several public health experts and practitioners from across the state and civil society sectors.

The surprise in Jharkhand is the much better training outcomes in terms of knowledge and even in recollection of topics covered. Except for topics like AYUSH remedies and animal bites which were rather specific to module 4 and even first aid and drug kit, in all other areas including childhood illness the learning and recollection was good. There is a case for studying the Jharkhand training modules closely and learning from it for the all India context.

Some issues that the VSRC team identified included non appointment of the mandated ten trainers, trainers trained at the state did not actually conduct the field training, high attrition rates among the NGO trainers, and assignment of areas to NGOs where they had not worked previously. The State NGO Coordinator specified that these problems affected the Module 3 and 4 trainings much more and were due in large part to problems in the release of funds to the NGOs.

Sahiyyas at the district level are being trained in disease control programmes to create awareness amongst communities and increase utilisation of services. Civil Surgeons of West Singhbhum and Dhanbad reported that trainings/orientations have been conducted for Sahiyyas on preparing blood slides for testing malaria and for DOTS follow up. In West Singhbhum, the Malnutrition Treatment Centre has also conducted an orientation for Sahiyyas on identification of severely undernourished children and referring them to the treatment centre for rehabilitation. According to the State RCH Officer, there is also a system in place for quarterly meetings at PHCs to reinforce the knowledge of the Sahiyya.

Over 60% of ASHAs have completed round 4, though in one of the two districts it is only 48%. In round 3 it is as high as 82% – with almost 96% in Dhanbad having got trained. Overall 92% of ASHAs reported getting less than 16 days of training with 55% from Dhanbad who got upto 15 days of training and 66% from West Singhbhum being trained only upto 10 days (Table 5). The surprise in Jharkhand is the much better training outcomes in terms of knowledge and even in recollection of topics covered. Except for topics like AYUSH remedies and animal bites which were rather specific to module 4 and even first aid and drug kit, in all other areas including childhood illness the learning and recollection was good. There is a case for studying the Jharkhand training modules closely and learning from it for the all India context.

Section 1d: Incentive Payments: Patterns and Perceptions

Assam

At the block level, all the money related to NRHM, including incentives are being deposited in one account. Incentives are paid to the ASHA through Account payee cheques. For payment of full immunisation incentive, there

is a 3 part voucher (for ASHA/ANM) for validation. The District accounts manager at the district and the Block accounts manager take responsibility for the payment. In Nilambazar block, they have divided all ASHAs under BPHC and 2 peripheral PHCs, and the ASHA receive their money from respective institutions. The state has also developed monitoring registers for institutional delivery and immunisation per ASHA so that monthly cheques can be given, combining all the amounts.

At the State level, respondents were not in favour of fixed payments. According to them the ASHA would then stop performing and become like ANMs. There would be no accountability and "everything will collapse". But they did advocate that amounts for incentives need to be higher. Some state officials felt that the ASHAs in difficult areas should get some 'retention fees' as their incentives payments would be smaller due to a poor functioning health system. At the district level, respondents mostly advocated for fixed payment, though the reasons were varied. Some of them felt that through fixed payment, they will be able to 'control' ASHA more. Some of them felt that the ASHA has to pay out of her own pocket for various things like referral transport, and travel and giving her a fixed amount would cover these expenses. In Nilambazar Block, officials said that they would budget for Rs. 500 as fixed payment for ASHA in the Block Health Action Plan and the incentives would be additional to this.

About 63% of ASHAs reported receiving a monthly reimbursement of upto Rs. 1600 in Assam.

Analysis from Phase 2 data show that about 63% of ASHAs reported receiving a monthly reimbursement of upto Rs. 1600 per months. Of these, 27% of ASHAs reported getting between Rs. 500–1000 per month, 36% got upto Rs. 1600 per month and 23% got more than Rs. 1600 per month. On the other hand 10% got between upto Rs. 500 per month and 5% got upto Rs. 150 per month.

Orissa

The state has several activities which are incentive linked for the ASHA. The state is now expanding this list. The range of incentive payment per ASHA per month is about Rs. 1000–2000. The team analysed the three month data of one sector from a better performing district (Angul). This district has an additional incentive component – Post Natal Care incentive as this is one of the three districts sponsored by NIPI. The analysis showed that in all the three months, half the ASHAs have got less than Rs. 1000. It is only 16% of the ASHAs who have got more than Rs. 2000. In this small sample, there has not been any major variation in the consolidated average for the different caste groups. But this may not be reflective of the entire state, especially in the tribal dominated regions. In one of the remote blocks visited, the highly tribal sub-centre had not had an ANM for six months and the ASHAs in that area therefore lost out on the immunisation and VHND money as well.

Findings from Phase 2 indicate ASHAs in Orissa are getting the highest incentives in comparison to other states especially in Angul district – as 64% of ASHAs said that they received more than Rs. 1000 per month, of which 82% were from Angul and 45% from Nayagarh.

Findings from Phase 2 indicate ASHAs in Orissa are getting the highest incentives in comparison to other states especially in Angul district – as 64% of ASHAs said that they received more than Rs. 1000 per month, of which 82% were from Angul and 45% from Nayagarh, 25% received Rs. 500 – Rs. 1000 per month (Angul - 16% & Nayagarh - 33%) and 8% got upto Rs. 500 per month.

The public display of ASHA incentive payments serves to motivate ASHAs to earn as much as their peers. The Mission Director at the state thought that

replacing the incentives with salary for the ASHAs would kill the programme. The district medical people were of the opinion that the ASHA would be hesitant to work once she starts getting a regular payment. The NRHM unit at the district and block level felt that the ASHA should get a minimum payment along with incentives. The minimum can be decided based on the last year's work.

Kerala

Nearly 56% of ASHAs reported getting upto Rs. 1000 per month and 20% got more than Rs. 1000 per month while 24% receive upto Rs. 500 per month in Kerala.

The ASHA are specifically incentivised for their activities in JSY, family welfare, immunisation, source reduction, ward health and nutrition days and NCD camps for screening. The incentive payment made to the ASHAs is performance based and they follow the Government of India guideline in this regard. ASHAs submit their monthly report to the JPHNs and the JPHNs submit the report to the respective medical officers. The medical officer submits the consolidated report of performance and claim format. The DPM ensures that the claims are processed and the money is transferred by 15th of the succeeding month and that is further processed and distributed to the ASHAs by 25th of the same month. The money is transferred through cheques by the JPHNs to the respective ASHAs. All claim and disbursement records are maintained at the sub-centre level. The medical officer plays an important role in the timely submission and disbursement of the incentives to ASHAs.

Nearly 56% of ASHAs reported getting upto Rs. 1000 per month (69% in Wayand and 42% in Trivandrum) and 20% got more than Rs. 1000 per month while 24% receive upto Rs. 500 per month. 37% ASHAs from Trivandrum got upto Rs. 1600 per month as against only 3% from Wayanad.

Rajasthan

In Rajasthan, ASHA received over Rs. 1000. ASHA is eligible for two fixed amounts of which Rs. 450 from the Health Department is not paid as regularly. About 37% reported being paid between Rs. 150 and Rs. 500 per month while 5% even less than Rs. 150 per month, indicating delays and non payment of even the fixed incentives.

The ASHA get fixed payments of Rs. 500 from Department of Women and Child and Rs. 450 from Health Department. Although national guidelines lay down clearly that the ASHA should get preference for incentives, the Dai, ANM, AWW, Yashoda and Jan Mangal Couple are competitors for the incentives related to institutional deliveries and the JSY. State level officials felt that despite efficient E-transfer mechanisms for fund flows upto the block level, there are delays in payment of incentives, because of problems in transfer of funds from the block to PHC level, accounted for partly by a shortage of accountants at the District Programme Management (DPM) units and in the hospitals.

The DACs shared that the major challenge that they face in the ASHA programme is timely payment of incentives, especially related to Janani Suraksha Yojana. Delays could range from one to three months. Incentives for immunisation have been delayed for over 2 years in some cases. The CMHO do not consider timely payments as their priority which they cannot facilitate due to the lack of their own managerial skills. The Accounts personnel at Bundi had initiated the development of an ASHA related work recording system. NGOs felt that the incentive payments should be replaced with fixed payments. Other stakeholders (MOs) felt that this would blur the distinctions between well performing and poorly performing ASHA.

About 51% of ASHA have reported receiving between Rs. 500 and Rs. 1000 per month, and 7% of ASHA received over Rs. 1000. ASHA is eligible for two

fixed amounts of which Rs. 450 from the Health Department is not paid as regularly. About 37% reported being paid between Rs. 150 and Rs. 500 per month while 5% even less than Rs. 150 per month, indicating delays and non payment of even the fixed incentives. Payments were more regular in Bundi than Banswada as 66% from Bundi reported getting between Rs. 500–1000 per month as compared 36% from Baswada.

Andhra Pradesh

The phase 1 evaluation estimated ASHA as receiving approximately Rs. 800 per month from all sources. In tribal areas, tribal department is paying Rs. 400 monthly and by adding incentive payments from other programmes, the net payment reaches to Rs. 1000. In order to make timely payment all incentives are brought under one head by the field staff for consolidating the claims under various heads. There is not much clarity with regard to the incentive payment at the District and PHC level. A circular issued by the government in July 2009 has clearly mentioned that the ASHAs will not be paid any fixed salary or honorarium and only performance based incentives. According to one DPHNO and one MO (PHC) any idea of giving fixed payment for ASHA's by the state should be discouraged. To motivate the ASHAs, it is necessary to link incentives with good performance.

Nearly half of the ASHAs reported getting less than Rs. 500 per month and 43% got between Rs. 500 and Rs. 1000 per month. 19% of ASHAs from East Godavari reported receiving even less than Rs. 50 per month.

Phase-2 survey shows that nearly half of the ASHAs reported getting less than Rs. 500 per month and 43% got between Rs. 500 and Rs. 1000 per month. 19% of ASHAs from East Godavari reported receiving even less than Rs. 50 per month. ASHAs from Khammam reported higher payments than ASHAs in East Godavari as 85% received upto Rs. 1000 pm while only 2% in East Godavari got the same.

West Bengal

Incentives are notionally "performance-based". ASHA gets Rs. 2 per house surveyed in the initial 2–3 months survey period (between Round 1 and 2), and after Round 2 she gets "upto" Rs. 800 per month, depending on her contribution to JSY, immunisation, ANC and house visits. This is not case-based, but based on the ANM's assessment of the ASHA's cohort register every month (in some blocks, this seems to happen every quarter). In practice, apart from a few exceptions, ASHAs appear to be getting a flat payment of Rs. 800 per month. When asked to opt between cash-based and fixed incentives, ANMs and ASHAs in at least two blocks unanimously preferred the fixed incentives option. Reasons stated are that cash-based incentives are unfair to ASHAs who have smaller populations to cover, it is unfair to blame the ASHA for people refusing services, cash-based incentives will mean that ASHA may refuse to do work that does not carry incentives, ASHA may bring cases anytime and demand payment – rather than when the ANM is able to attend to them). ANMs are confident that they will be able to "take work" from ASHAs who are paid a fixed compensation.

All ASHAs in West Bengal reported receiving Rs. 800 pm (between Rs. 500–1000) which indicates that all ASHAs are receiving monthly payments according to the state norms of Rs. 800 – which unlike in Rajasthan is implemented with much greater regularity.

All ASHAs in phase 2 survey reported receiving Rs. 800 pm (between Rs. 500–1000) which indicates that all ASHAs are receiving monthly payments according to the state norms of Rs. 800 – which unlike in Rajasthan is implemented with much greater regularity.

Bihar

Payments are incentive based and the state has issued directives to all districts to ensure that all ASHA have bank accounts into which the incentives can be directly deposited. Coordination of fund flow and record keeping between various vertical programmes that form the programme is done by the PHC. There is a planned shift to monthly and composite payments through bank transfers.

Bihar shows the most variance in payment amounts. About 33% of ASHAs got over Rs. 1000 per month, 15% got upto Rs. 1000 pm, 22% got between Rs. 150–500 per month, and 31% received less than Rs. 150 per month.

The senior leadership in the state perceives that ASHAs are not staff and that money should be secondary in this programme. According to Project Manager, monthly honorarium would kill the programme and task based cash incentives are fine. But the programme managers feel that fixed payment is better as it allows ASHA to do a variety of tasks and not get restricted to just the incentivised ones. At the block level, one view is that ASHAs will become lazy if they start getting fixed payment. Others feel that fixed payment is better as it would give the block officials greater control over ASHAs and also, the ASHAs would feel more attached to health department and thus ready to do anything they are asked to do. Another view is that ASHA should be paid a fixed payment as they are doing so much work for the health department and Government must think of their contribution. ANMs also feel that fixed payment should be given to ASHAs.

At the block level, informants feel that the frequent changes in guidelines on whether to give in cash or through bank are problematic. There is no monitoring system in place to check flow of incentives to ASHAs. District level authorities have blamed the block level informants for delay in payments. However, block level informants feel that there is delay from districts on sending the funds. ANMs expressed that when funds are available in the PHC the ASHA get paid. Views are varied regarding fixed payment issue to ASHAs. State and district level respondents are not generally in favour of fixed payment.

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Jharkhand

In Jharkhand only 9.5% getting more than Rs. 1000 per month, 29% receiving between Rs. 500 and Rs. 1000, and 24% between Rs. 150–Rs. 500 per month.

Incentives are being provided in respect of JSY, post partum care, and immunisation. Jharkhand gives performance awards to Sahiyya who receive the highest amount of incentive. Senior state level leadership perceived that a monthly honorarium was preferable otherwise the incentives encourage a curative rather than preventive focus.

In Jharkhand only 9.5% getting more than Rs. 1000 per month, 29% receiving between Rs. 500 and Rs. 1000, and 24% between Rs. 150–Rs. 500 per month. About 38% got even less than Rs. 150 per month, of which 59% were from Dhanbad as compared to 16% from West Singhbhum.

Section 1e: Drug Kits: Supply and Replenishments

Assam

In Assam, drug kits were distributed two years ago. Out of 28,700 ASHAs (including the new 3500), more than 26,000 have received drug kits. Refilling

is done at PHC level. Until recently, there were problems in replenishment, but now dates have been fixed for ASHA to visit PHC monthly for refilling. In Karimganj district, refill is from the PHCs but the amounts are inadequate. District officials suggested that drugs should be supplied biannually. Some ASHAs were trained on malaria and provided Chloroquine and RDKs. In Dibrugarh district refill of drugs appears to be problematic. In all, the ASHAs were mostly given IFA, condoms and paracetamol. They were made to give cotrimoxazole only in the presence of the ANM. State level respondents felt that ASHA should dispense certain drugs but do not see that as her main role. At the District level too the views were similar. In fact in one block, drugs had not been replenished as the SDM and HO was not convinced of the idea. The team found unused supplies of IFA and in few instances cotrimoxazole was lying unused with the ASHAs. Many respondents were of the opinion that role of dispensing drugs should be left with ANM.

Phase 2 data shows higher availability of drugs in Karimganj district with ASHAs. Overall 95% of ASHAs reported having drug kits on the day of interview. Of these, 44% ASHAs from Karimganj had ORS and Chloroquine in their drug kit, 35% had paracetamol and 12% had cotrimoxazole. A huge inter district variation can be observed as only 2% in Dibrugarh who had chloroquine and 1% who had ORS while none had Paracetamol and cotrimoxazole.

Kerala

In Kerala a drug kit is being provided to all ASHAs. Many officials felt that ASHA in Kerala does not need a drug kit, except in tribal, hard to reach and coastal areas. This was mainly explained due to the presence of adequate number of qualified physicians and specialists in Kerala, where even immunisation sessions are held in front of the doctors. Even JPHNs/JHIs do not prescribe drugs hence the ASHA's drug dispensation role is questionable.

About 95% of ASHAs had a drug kit on the day of interview, of which only 29% and 14% had ORS with them in Trivandrum and Wayanad respectively. Availability of drugs like Chloroquine, Cotrimoxazole and Paracetamol was upto 20% in Trivandrum where as it was upto 8% in Wayanad, with figures as low as 1% for Chloroquine and Cotrimoxazole.

Rajasthan

In Rajasthan, interviews with state level stake holders indicated that the entire drug kit has not been received by the ASHAs in all districts. In some places drug kits have been supplied from the ICDS structure but are replenished through ANMs or through PHCs. However a few drugs such as Paracetamol, ORS packets, IFA tablets and chloroquine, have been distributed to the ASHAs from the district level. These are provided on a monthly basis, and the supply is regular. At District Level, the DAC from Kota and Banswara shared that the supply of selected drugs is regular, though the entire drug kit is not supplied. The ANM is responsible for supply of drugs to the ASHA.

Phase 2 data shows only 62% of the ASHAs having a drug kit on the day of interview (73% in Bundi and 50% in Banswara). Of these ASHAs only upto 10% reported having paracetamol, chloroquine, ORS and cotrimoxazole in both the districts.

Andhra Pradesh

In Andhra Pradesh the DM and HO provide drug kits to all the ASHAs and replenishment is done on ASHA day and during the month from the ANM. One Malaria officer said, not many drugs should be given to ASHA because they can be used irrationally. However the point was made that life saving drugs such as methergine could be dispensed by ASHA.

Overall 90% of the ASHAs had a drug kit on the day of interview, of these higher availability of drugs was reported by ASHAs from East Godavari – 34% had paracetamol, 31% ORS, 24% had cotrimoxazole and 21% had Chloroquine. The respective figures from Khammam were lower 13% for paracetamol, 16% for ORS, 11% for Cotrimoxazole and 23% for Chloroquine.

West Bengal

In West Bengal the ASHAs were not yet trained for the use of drug kit, but the drug kit in Birbhum has been supplied in many blocks. In some places the ASHA are already dispensing chloroquine, metronidazole, paracetamol and norfloxacin with guidance and instructions of the PHC Medical officer.

Phase 2 data shows a high difference between the two districts. 73% of ASHAs had a drug kit on the day of interview, of which 91% had ORS, 89% had paracetamol, 70% had cotrimoxazole and 24% had chloroquine. On the other hand 80% of ASHAs from Malda reported having a drug kit, of these 40% had cotrimoxazole, 27% has ORS and paracetamol and 21% had chloroquine.

Bihar

In Bihar, the ASHAs have not received the drug kit. Only first aid materials, pregnancy tests, ORS and IFA have been given in some places so far and that too irregularly. All the key informants have shared that there is a need to provide drug kit for ASHAs and are in favour of including antibiotics in the drug-kit.

Jharkhand

In Jharkhand, the Sahiyya has received the drug kit which is expected to be replenished at the PHC level. In Jharkhand, West Singhbhum performs much better than Dhanbad as 73% of ASHAs in West Singhbhum had drug kit whereas only 24% had a drug kit in Dhanbad. In West Singhbhum, 30–40% of Sahigyas reported having ORS, paracetamol and chloroquine while only 14% had cotrimoxazole. In Dhanbad, less than 10% had paracetamol and cotrimoxazole and 13% had ORS and Chloroquine in their kit.

Section 1f: Village Health and Sanitation Committees, Social Mobilisation, and Social Exclusion

Assam

More than 24,000 VHSCs have been formed out of the target 26,000 – one per revenue village. Only in Goalpara district they have not been formed as

PRIs are not in place. The VHSC have been instrumental in selecting new ASHAs. The state has already initiated VHSC trainings in 13 districts where training of trainers has been completed in co-ordination with Total Sanitation Campaign and Public Health and Education Department (PHED). The trainings will be rolled out through the MNGOs and FNGOs. ASHA is a campaigner and facilitator of the VHSC.

Village planning has been initiated in selected villages in each block. Training for this has been completed and the Block programme managers will facilitate the process in the block. A template has been prepared for this. There will be a household survey first where issues will be identified and then planned for.

For the last two years Rs. 10,000 has been allotted for each VHSC but the release was delayed because of the time taken for formulating the guidelines. The nature of utilisation shows that a centralised decision has been made regarding how to spend the untied fund. This view was reinforced in the districts as we found the expenditure pattern is same. The fund has been utilised in buying weighing Machine, chair, table, BP machine, referral transport. For promotion of toilets, it has been decided that Rs. 300 would be given per household, to ten most needy households for constructing toilets.

More than 24,000 VHSCs have been formed out of the target 26,000 – one per revenue village in Assam. The VHSC have been instrumental in selecting new ASHAs. The state has already initiated VHSC trainings in 13 districts.

At the state level, the respondents were positive about VHSCs and the participation of PRI in health. Respondents in both districts felt that VHSC was very useful as it can undertake local health related activities but some were very apprehensive about the motives of the PRI members. They were of the consensus that training of VHSC members is essential and that it is not enough to just disburse funds.

There appears to be some reluctance at the Block level of getting PRIs involved in health issues, on account of the perception that the politically active members would start making unreasonable demands on the health system.

Exclusion: At the state level, the areas requiring special assistance were listed as-Tribal Districts, Border districts Flood prone districts. In the border area, there are ASHAs but no Institutional Deliveries due to lack of roads. The health department officials have had meetings with PRIs and tied up with MNGO for referral transport to be paid by them. In Dibrugarh, the respondents identified communities living and working in Tea Estates as vulnerable groups. Their language is different (mixture of Oriya and Assamese), and despite high literacy levels, adolescent pregnancies appear to be on the rise. ASHAs are already working amongst them and are perceived to have made a significant difference in their access to health services. The district is also planning to select CHWs who are similar to ASHA but less educated and looking after fewer households, from that community and train them on health issues so that they are able to further improve the situation.

Another set of vulnerable population in Dibrugarh are the ones living on river islands. Boat clinics have been started with help of a renowned NGO. But the ASHAs in these islands are not being supported adequately as most of the ASHA Facilitators are from the mainland and are rarely able to visit them. There is need to appoint ASHA Facilitators based in these islands. This year 3500 ASHAs have been newly selected to cover remote hamlets. Special initiatives like RCH camps, ensuring that every hamlet has ASHA, every sub-centre has ANM, MMU, Boat clinic, incentives to staff working in remote area e.g. special mobility support for ANMs. In districts such as Dhemaji which faces insurgency

and influx of immigrants, the immunisation rate has risen to 90% as it has been made mandatory for ASHA and ANM to check every child. ASHAs have been successful and hope to be able to cover more such populations with the new ASHAs. They need more institutional support. It was suggested that 'ASHA retention fees' should be given to ASHAs in difficult areas who are not able to receive much incentives due to poor functioning of health system.

Orissa

Village Health and Sanitation Committees known as Gaon Kalyan Samiti (GKS) have been formed in Orissa. The ASHA is a member of this committee and is expected to attend the GKS meetings, mobilise community and raise issues relating to health in the village.

Village Health and Sanitation Committees have been formed in the state, known as Gaon Kalyan Samiti (GKS). The state has designated the Anganwadi worker as the Convener of the GKS which makes her the joint signatory of GKS bank account along with the Ward member who is the Chairperson of GKS. This was designed for better collaboration with the ICDS (Integrated Child Development Scheme) and because, the Anganwadi worker's existing experience of reporting meant she was better positioned to manage accounts. The ASHA is a member of this committee and is expected to attend the GKS meetings, mobilise community and raise issues relating to health in the village.

To sensitise the GKS members on its importance and provide orientation on utilising the untied fund, a communication campaign was launched in January 2009. However, district authorities mentioned that more effort is needed to develop a better understanding in some blocks regarding effective utilisation of funds. To ameliorate this problem, training of GKS members is underway, and 100 out of 1563 GKS in Angul have received training. Village health plans have been initiated in some of the blocks and 867 of the 1389 GKS in Nayagarh district have formed plans. The village health plans need strengthening and the GKS need capacity building. The state is planning to involve development partners and NGOs for the capacity building programme of GKS.

Exclusion: Discussion at state level demonstrated understanding of the issue and motivation to address this. For example efforts were underway to increase the number of ASHAs in the KBK region to 1/300 population as opposed to the norms of 1/1000. However further analysis and sensitisation is required to understand inter – and intra-community differences at the district, block and community levels and there seems to be a need for innovative solutions to reach the most marginalised, without social disruption.

Efforts were underway to increase the number of ASHAs in the KBK region to 1/300 population as opposed to the norms of 1/1000.

Last year there were disproportionately more deaths reported in the underserved tribal areas, and one District Programme Manager felt that these were the areas in which there would be further unreported deaths occurring in homes, meaning this inequity could be further accentuated. The team looked at the mortality statistics for one month in one of the districts and found this is disproportionately high in ST/SC groups. The reason was ascribed as "ignorance and illiteracy" among the affected groups by several respondents at district and block level. As mentioned earlier, an appreciation of clear disaggregated mortality indicators, will go a long way to understanding these issues from the perspective of the poorest and delivering distributive justice.

During discussions the team found that there are divides and discrimination within communities. For example an ASHA belonging to an SC community is not allowed to accompany upper caste women to labour and in the process misses out on incentives, although she would like to carry out these activities.

Kerala

The committees at village levels are called Ward Health and Sanitation Committees (WHSC) they are involved in ASHA selection and also in the management of ASHA programme. The ASHAs work very closely with the ward health and sanitation committees and they are also members of the committee. The WHSCs are issued guidelines on the roles and responsibilities of ASHAs and they are also oriented about the programme through workshops conducted by District and Block program units of NRHM. Although the ASHAs are involved in planning, only short term planning is done only for 1 to 3 months. The ASHAs play a major role in source reduction. They are also incentivised for their work in source reduction. Another major task of the ASHAs is coordinating the ward health and nutrition day. ASHAs also help to coordinate the programmes in connection with WHND.

The NRHM in Kerala has initiated a media initiative on spreading the programme details and campaign messages. All districts are publishing their newsletters apart from the state level newsletters. There is a regular radio programme that addressed issues related to community participation health. TV and Movie clippings have also been extensively used. Print media advertisement campaigns are on, some districts have organised Kalajathas as well. Ward Health and Nutrition Day is also a strategy for social mobilisation.

The ASHAs work very closely with the ward health and sanitation committees and they are also members of the committee. The WHSCs are issued guidelines on the roles and responsibilities of ASHAs and they are also oriented about the programme through workshops conducted by District and Block program units of NRHM in Kerala.

The state consultant for the ASHA programme feels that beyond orientations regular training is necessary for WHSCs in order to optimise the ASHA programme. One DPM felt that there should be long term planning with commensurate increase in funds. There is also the feeling that the involvement of WHSCs in the ASHA programme should be more structured and streamlined.

ASHAs play a much needed role in taking awareness and health care facilities to the most needed population in tribal areas, coastal areas and urban slums. While the state relaxed the population norm in geographically hostile terrain, the representation of ASHA from SC/ST communities was not proportionate to the population. The state did not also relax the educational criteria for selection. Panchayat representatives reported in some places where they could not find an ASHA who met the educational qualifications, they selected women from different localities and deployed them as ASHAs in a distant area. This also affects the ASHAs ability to work, given the fact that she requires funds for transport to commute to the village where she works.

Rajasthan

By February 2009, VHSCs were constituted in all districts. This Committee is formed at the revenue village (more than one such village may come under a single Gram Panchayat). Members of the VHSC consist of: the ASHA, Anganwadi Worker, ANM, SHG leader, Sarpanch, village representative of any community based organisation working in the village. The chairperson is the GP member and the convener is the ASHA when in position (The AWW may serve as the convenor if the ASHA is not available). A VHSC training module has been developed with the support from CHETNA, Ahmedabad and Voluntary Health Association of India (VHAI). Trainings scheduled to start from November 2009 were postponed due to the recent Panchayat elections.

While the VHSC have been formed in Rajasthan, in many the membership does not exceed 5 and there have been no meetings held in many districts (e.g. Banswara). It is still too premature to ascertain the role of the VHSC as a primary support structure for the ASHAs.

The entire state VHSC training (2,80,000 members) has been distributed among 12 NGOs, with each NGO assigned 2 districts to undertake the training of about 2,000 members in three days. It appears that the use of un-tied funds is primarily used for cleaning of the areas surrounding the hand pumps. More recently un-tied funds of the VHSC have been mandated through a state order for the organising of community mobilisation meetings and pad yatras.

While the VHSC have been formed, in many the membership does not exceed 5 and there have been no meetings held in many districts (e.g. Banswara). It is still too premature to ascertain the role of the VHSC as a primary support structure for the ASHAs. As the convener and secretary of the VHSC, the ASHA is cognizant of the need to record the meetings and its minutes. In Bundi it was noted that the minutes register was filled with identical minutes of each meeting, almost all shown to be held on Sundays. Despite an incentive of Rs. 100 per month for convening these meetings, meetings are not regular. People's participation as well as the attendance of the elected representatives is not regular. The role of the PHC facilitator in conducting these meetings is unclear. In large villages with multiple ASHA, the resolution of which ASHA receives the monthly incentive is made by rotation. Module 5 aimed at training the ASHA in social mobilisation has not yet been introduced in the training schedule, given the delay in completing the other rounds.

The rights based approach to health does not seem to be translated in the orientation, training, or mentoring for the ASHA, except perhaps when training is undertaken by NGOs. IEC department at the state level produces posters and charts for distribution at the district level. Apart from sporadic NRHM advertisements on television, there are few isolated attempts by the media to highlight the role of the ASHA.

Exclusion: In the Western districts of Rajasthan, the ASHA are sparsely distributed. The caste system and the distribution of villages into hamlets appear to dominate the accessibility of services in the State. ASHA of higher castes refuse to accompany lower caste women for services though they cloak it in the garb of the rejection of ASHA. Similarly high caste women refuse to have lower caste women accompany them to institutions for services. On the issue of education district officials perceived that a basic level of education beyond Class VIII was necessary if ASHA were to achieve the competencies required for behaviour change on issues such as child marriage, and gender discrimination that is still rife in Rajasthan's feudal society.

No formal trainings have been carried out for the VHSC members, and Village health plans are not stressed upon in Andhra Pradesh. Spending of Untied funds are largely dictated by the Sarpanch in most places, the ANM occasionally and rarely by the ASHA.

Andhra Pradesh

The state has built upon the existing Panchayat level Village Health and Sanitation Committees. They meet every three months, and perform just perfunctory roles. The health department staff refers to them as Sanitation Committees and perceive their role as keeping the village clean. Each VHSC has an existing account, into which the untied funds are deposited. The account is operated by the ANM and the Panchayat sarpanch.

No formal trainings have been carried out for the VHSC members, and Village health plans are not stressed upon in Andhra Pradesh. The weak VHSC role has been felt, and the senior leadership at state level said that there is a serious need to sensitise the Panchayat on NRHM. Spending of Untied funds are largely dictated by the Sarpanch in most places, the ANM occasionally and rarely by

the ASHA. Most ASHAs were not even aware of the expenses in the untied funds. VHSC have a definite role to play and a weak VHSC is reflected in the lack of Community Monitoring process and negotiations with the System.

According to one DPHNO, village administration can play a major role in ASHA programme if sensitised about such initiatives. According to senior state officials, GP members and therefore VHSC are temporary members changing every five years. They do not show interest in these activities except money! There has not been a major social mobilisation strategy to get them involved in health. There is a felt need expressed by the officers from the state downwards that the Panchayats need to be mobilised for health. There is a mass media campaign on health, but it does not mention the benefits of working together at the Panchayat level for health.

Exclusion: The state has a sizeable Scheduled Caste and Scheduled Tribe population, and it also has an extremist affected zone. Initially there was more compensation for SC and ST ASHAs as compared to other ASHAs. In tribal areas, ASHAs have to deal with seasonal migrants. ANMs and ASHAs are facing difficulties in reaching those areas. In both the districts, tribal hamlets particularly in hilly areas which are cut off during the rainy season exist. In fact some of these locations are not accessible even in other seasons given the remoteness of the districts.

West Bengal

Gram Unnayan Samity (GUS) is an existing structure present in the PRI system in West Bengal, and this is now mandated to play the role of VHSC. This meets and approves budgets, but has no specific roles in the health programs. Untied funds are available at SHC and block levels. There is evidence of utilisation of functioning of RKS at sector PHCs to raise funds and utilise them for repairs, etc. One Pradhan mentioned use of funds for making repairs at the SC. The extent of use of these untied funds needs careful verification. Only about 16,000 GUS exist (out of a potential ~ 60,000 sansads/villages). Due to political violence in rural Bengal post Panchayat elections in 2008, GUS have not been formed in many places.

GUS do not play an active social mobilisation role, but some posters, and loud speaker announcements, dhol (form of village communication) were used mostly for advertising the ASHA positions.

Exclusion: The only kind of obvious marginalisation accepted by official is geographical – for instance, a cut-off island suffers, irrespective of caste, religion – or even political affiliation. ITDP blocks were prioritised when selecting blocks for the ASHA programme. However vacancies among ASHA are higher in tribal areas. The percentage of ASHAs selected from SC/ST is slightly less than their percentage in the district population-at least in the sample studied.

Bihar

The existing Gram Panchayat level Committee has been co-opted as VHSC in Bihar. So the VHSC is at Gram Panchayat level rather than at revenue village level. For example, Khagaria, has 306 revenue villages, but only 129 VHSCs in the district. 109 out of the 129 have bank accounts and have received untied funds recently. The ANM and Panchayat president operate the account.

The existing Gram Panchayat level Committee has been co-opted as VHSC in Bihar. The ANM and Panchayat president operate the account. ASHA is not part of the VHSC, but part of a village level monitoring committee (Nigrani Samiti) which consists of SHGs and is expected to monitor the VHSC.

ASHA is not part of the VHSC, but part of a village level monitoring committee (Nigrani Samiti) which consists of SHGs and is expected to monitor the VHSC. These are still in the initial stages and yet to become functional.

The understanding of district officials on VHSCs was limited. Key informants from state to the district level perceived that untied funds are to be used for referral transport, health camps and village sanitation and hygiene. Some district officials feel that ASHA has no role in VHSC and treat them as two separate programmes. Selected block level officers felt that VHSCs can be useful for organising health camps, immunisation sessions, drug purchase, all locally. All the key informants expressed the need for training VHSCs in Village Health Planning.

Lack of social mobilisation around VHSC and handling of bank accounts by powerful Mukhiyas jointly with ANM are negative influencers of the programme as cited by some district respondents. Even though the ASHA does not have any role in the formation and management of VHSCs, key respondents felt that, ASHAs should facilitate VHSCs. All the key informants have visualised ASHA programme as a programme for social mobilisation only in terms of getting more cases to the PHC. There were no social mobilisation activities undertaken during the initial phases of operationalisation of the programme. ANMs in Khagaria expressed that ASHA in such villages are unable to motivate communities for health services as they are non literate and have little interest in the programme.

Exclusion: Perception of social exclusion was weak amongst officials. Block level informants felt that ASHA were able to reach the marginalised sections. In Khagaria at distinct and block level, stakeholders felt that there were no disadvantaged sections in the state. In Purnia, there was acknowledgement that such sections existed and ASHA is succeeding in reaching them. It appears that medical officers are less positive about the benefits for active community mobilisation than the non-medical cadre of District Programme Managers. Some districts such as Khagaria, (in addition to East Chamaparan, Saharasa, Madhepura, and Kishanganj) are flood prone, and often villages are cut off, leaving large swathes of underserved population.

Jharkhand

Village Health Committees (VHC) were created prior to the selection of the ASHA as they were intended to be the mechanism through which ASHA would be selected. A majority of the members were expected to be women and the VHC had three office bearers (President, Secretary and Treasurer), to be selected at a Gram Sabha/Aam Sabha meeting. Once the Sahiyyas were selected the VHCs were allowed to languish and had no role to play in either the Sahiyya programme or in other health programmes of the state. In 2008–09, the VHCs were revived due to the availability of untied funds under the NRHM and guidelines for the use of the untied funds were circulated. However these guidelines were confusing as they provided for the opening of a joint bank account for the VHC in the name of the VHC President or the Village Head and the Sahiyya/Anganwadi Worker or the Health Link Worker.

In West Singhbhum (a tribal district), the study team found that bank accounts had been opened in the name of the Sahiyya undermining the three office bearers previously selected whereas in Dhanbad (a non-tribal district) bank accounts were opened in the name of the VHC President and the Sahiyya. As per official records, funds had been transferred to 1138 of a total of 1543

VHCs in West Singhbhum, however the Sahiyya and VHC members in Gelealor Village of Chakradharpur Block in West Singhbhum were not very confident about the use of the funds and the Sahiyya reported that the main expenditure till date was the purchase of a water jug and glasses to be used during the VHC meeting. The Accounts Manager had further asked all the Sahiyyas to purchase a table and chair from the untied funds and while the Sahiyya interviewed had not made the purchase reported that several other Sahiyyas had indeed purchase a table worth Rs. 1000 and a chair for Rs. 280. The VHC in the village had only one meeting since its formation and the VHC members appeared reluctant to meet citing the non-availability of time as the main constraint. Moreover, at a PHC in Chakradharpur block officials shared that Sahiyyas were expected to submit the expenditure statement of the VHC untied fund to the PHC and the expenditure could be considered a valid use of the fund only if the Accounts Manager deemed it to be so.

Thus, in West Singhbhum, VHCs appeared to be largely defunct with health officials, VHC members and Sahiyyas lacking clarity on its role as well as the utilisation of untied funds. On the other hand in Dhanbad, the VHC visited was clear that its role was to help poor people access services. It had received the untied funds in 2008 and had utilised it for purchasing medicines for the poor, cleaning the village pond, repairing the hand pump and facilitating deliveries. The VHC members reported holding regular meetings in which they discussed measures to prevent seasonal diseases like malaria and diarrhoea.

One notable aspect of VHC's functioning was that they conceived of their role as entirely focused on expending the untied funds in Jharkhand.

One notable aspect of VHC's functioning was that they conceived of their role as entirely focused on expending the untied funds in Jharkhand. During the course of the discussion, the members identified several issues in their village, such as the difficulty experienced by residents of one of the hamlets in accessing the Anganwadi Centre and the AWW distributing less than the mandated amount of Take Home Rations to pregnant and nursing mothers and children less than 6 months of age. Despite this, the VHC did not feel that they had a role in addressing these issues. In Dhanbad block, Sahiyyas had reported that their identity was derived entirely through the cooperation and indulgence of the ANM and did not feel that the VHC could help them in challenging the status quo and establishing their presence. Sahiyyas were largely seen by all health officials as a means to bring patients to the health services rather than vice versa and VHCs are perceived as committees set up for the expenditure of untied funds. These community based processes are currently not oriented towards social mobilisation.

Section 1g: Framework of Understanding (Programme Theory) and Perspectvies of Various Officials

Assam

At the state level, the perception of the Mission director is that the ASHA should be a link worker with limited skills of low level service provision in disease control programmes. Other state officials see ASHA mainly as a facilitator of health services and that motivating community for institutional delivery and immunisation are the ASHA's most important roles. She could get involved in RNTCP and leprosy only after few years. The other concern is that expanding

the ASHA's role would allow the ANM to shirk her duties. They do not explain how this is consistent with the drug kit, or the work they are actually doing. They do however read the centre's guidelines as requiring a mix of roles and have complied.

At the district level she is seen as both a facilitator of services for RCH and as a service provider as she provides drugs, makes malaria slides, does pregnancy testing using Nishchay kits, undertakes nutritional counselling, and is able to mobilise underserved (or reluctant families who would otherwise not use services), to access services and is seen as the bridge between community and health department. The priorities are institutional delivery, immunisation and ANC. Some of the district respondents were concerned that workload on ASHA is increasing and sometimes it appears that the ASHA is being given responsibilities that other staff are unable to handle. District officials said that ASHA is expected to attend weekly immunisation and ANC sessions at village and sub centre, a biweekly meeting with the ASHA facilitator, and a fortnightly/monthly meeting at the block level. This shows that for at least 4 days a week she has to be present in session or meeting and this usually takes the whole day. If she were paid a full day's wage for this, it would be acceptable but this is clearly not so.

In Assam, there is a divergence in the programme theories of state, district and field staff, with the state officials subscribing to the purely link worker role, the district and field clearly articulating her role in conformity with programme theory 2.

At the field level, the ANM were appreciative of ASHA's role in enabling the increased utilisation of services. According to district officials, as a mobiliser she has broken down resistance to various services. She is also functioning as a social activist as her bargaining capacity is increasing. For e.g., in Patherkhandi, she negotiated and got bank accounts of pregnant women opened with zero balance. In certain areas she also monitors SNP and timings of the Anganwadi. In Panitola, ASHAs have been involved in resolving domestic fights and helping victims of domestic violence. In the same block they have also managed to demand services for informal labour from Tea Estate Hospitals. In certain districts like Chirang, ASHAs have formed organisations to demands rights and entitlements of the community. Therefore in Assam, there is a divergence in the programme theories of state, district and field staff, with the *state officials subscribing to the purely link worker role, the district and field clearly articulating her role in conformity with programme theory 2,* but conceding too, that there is lack of role clarity between various field staff, as well as little consideration of the time taken by ASHA to undertake all that is expected of her.

Orissa

Most respondents felt the ASHA spans a range of roles including community mobiliser, health service facilitator and service provider to varying extents. State level respondents took a broader view of the service provider and activist role as compared to other states, but also highlighted the need for this to be driven by incentives. As a general trend it was also noted that respondents from the Health Services regarded her more as service provider and link worker to their functions, while National Rural Health Mission (NRHM) respondents tended to emphasise her 'activist' role more. The ASHA advises the pregnant woman about registration and check up, mobilises the community for immunisation and accompanies pregnant women for institutional deliveries. Other important activities are making of malaria slides, and dispensing medicines. This was appreciated by the district medical officers especially in malaria prone areas where they believed the ASHAs play an important role in preventing complication by referring acutely unwell patients. ASHAs also act as DOTS providers in the

community and promote contraception. All these activities are incentive linked. The Chief District Medical Officer viewed the role of ASHA as "adjuvant to the health system" and felt ASHA assists the Auxiliary Nurse Midwife (ANM) and Anganwadi worker, whilst also acting as an advisor to the community. Despite this "adjuvant" position, he felt it would be positive if ASHAs raised grievances with regards to service provision by government functionaries, enabling accountability. Respondents in more frequent contact with ASHA at block and sub-centre levels were more inclined to equate her role to the set of activities for which she received incentive payments. However, the block team said that about 70 percent of the ASHAs perform functions which do not carry incentives also, because the ASHA works to gain community acceptance regardless of the incentives. Examples of such work included distribution of bleaching powder and Oral Rehydration Solution packets during monsoon epidemics. Despite the varied conceptions of ASHAs role, it was commonly felt that "she is the backbone of NRHM" and the Mission Director said that most of the credit NRHM receives is because of the ASHA and felt this should be recognised. We find that in Orissa respondents *largely view the ASHA through the frame of programme theory 2.*

Despite the varied conceptions of ASHAs role, it was commonly felt that "she is the backbone of NRHM" and the Mission Director said that most of the credit NRHM receives is because of the ASHA and felt this should be recognised. We find that in Orissa respondents largely view the ASHA through the frame of programme theory 2.

Kerala

ASHAs have been largely seen in the frame of an extension worker of the department with some social mobilisation and health education roles, and these are limited to the role that ASHAs are playing in other states, largely around the RCH areas and national programmes. Although state level officials were of the view that ASHAs are needed to lead the community control of non-communicable as well as communicable diseases, the programme design to establish and to achieve such a role was not clear. Another much publicised role for ASHA was to support palliative care initiatives but in the existing pilots, the ASHA was playing the limited role of a community assistant. State level officials felt that ASHA was needed to fulfil the community level tasks of the health department, which the Junior Public Health Nurses (JPHNs) and Junior Health Inspectors (JHIs) are unable to undertake. State officials feel that the community systems building and follow up, especially in the tribal and coastal areas could best be undertaken by ASHA. She is needed to fill in the gaps of social mobilisation for health programmes and Health education. Block level downwards, the officials said they needed ASHA for the community extension worker role. So far as the JPHNs and JHIs were concerned, they were seeing ASHAs as their first assistants, as a cadre, to whom they wanted to shift many of their roles (data collection, surveys). For Panchayat members, ASHA was a community informer, where in they expected ASHA to support all the activities in Panchayat Health Plan. None of them were seeing ASHA as a service provider or as promoting women's empowerment even though many ASHA were involved as volunteers in the state's women's development programme – Kudumbashree. *In Kerala it appears that from state to PRI all stakeholders firmly belong to the school of thought that subscribes to the first framework of understanding.* It was difficult for all sections-from the state official to the ASHA to explain what would be the value addition she could do in RCH as link worker/facilitator when already there was such a high level of awareness and appropriate health seeking. In NCDs her role was to mobilise persons above 30 to attend NCD camps-but to what extent this would give measurable health outcomes was not clear to anyone.

In Kerala it appears that from state to PRI all stakeholders firmly belong to the school of thought that subscribes to the first framework of understanding.

Rajasthan

ASHA's role as a community mobiliser is extremely weak because a majority lacked the required skills of mobilisation and communication and this seemed to matter more in a largely tribal district such as Banswara.

The health system respondents at all levels, and more so the field and block level officials, immediate seniors of the ASHA, at the community level insist that the ASHA play the role of a link worker, rather than the mobilisation role. They see her role *primarily as a link worker*, enabling facilitation for services, pleading that there was no time for her to do anything else. The senior leadership at the state level is reported to have said that the ASHA's role needs to go beyond raising awareness, but was not more specific than that. This is reflected in the training she receives. In Rajasthan, most block stakeholders felt that the role of the ASHA should go beyond maternal and child health, but that the ASHA required further training. Her role as a community mobiliser is extremely weak because a majority lacked the required skills of mobilisation and communication and this seemed to matter more in a largely tribal district such as Banswara. The MOs seemed to have no objection to the ASHA using drugs some stating that "dilution of medical knowledge" was necessary.

Andhra Pradesh

The NGO which conducted the training had a framework of understanding that saw ASHA as only a health activist. Most state officials and district medical officers were in a framework of understanding-1 In contrast ANMs and ASHAs shared a more pragmatic understanding in line with national guidelines-what we called the framework of understanding-2 in Andhra Pradesh.

There were marked differences at each level. At the state level officials expressed that the primary role of ASHA was to focus on Janani Suraksha Yojana and the immunisation programme. To some extent the ASHA is helping to generate awareness in the community about health issues and also enabling greater utilisation of public health services as against the private health services. The *ASHA is mainly a link between the community and health systems and also serves as the voice of the community.* Representatives of the NGO that trained ASHA regretted that the ASHA is not an activist as they had envisaged, but what she stated was "an agent of the government," implementing the government's limited schemes. This NGO subscribed to the view that the ASHA was a rights activist and were disappointed at the facilitator role she now undertakes. They also alleged that ASHAs have become commission agents, making money for themselves and also paid by the private practitioners at times for their services.

The Medical Officer and the DPHNO viewed ASHA as link workers who could get people to the hospital under the JSY. The state EMRI and HMRI services (108 and 104) have a list and mobile numbers of the ASHAs in the area, and view her as their local support and guide in the village. Some Medical Officers did mention that the ANMs have now become lazy since ASHA has taken over her role and more serious cases or those requiring delivery are sent off through EMRI. One medical officer at a PHC said that the ASHA role can actually be played by the ANMs provided the state gives more incentives and recruits more ANMs at the PHC. According to him the ASHA programme has created a management burden on the PHC in terms of logistics, budget etc. Key informants at the district level feel that ASHAs are being used by political groups to raise demands, such as fixed salaries and uniforms and vehicles.

The ANM looked upon the ASHA as assistants in ensuring that people received health services and reached health institutions. Some ANM listed the functions that ASHAs could perform on regular basis at the village level such as taking care of newborn, know how and where to refer high risk pregnancy, take care of minor illness in the village, and advise women on nutrition. ANMs in Enukuru PHC in Khammam district shared that ASHAs are very useful in

their work. They help in immunisation, identifying pregnant women, ANC registration, and distribution of iron tablets. The ANMs further shared that their work load has been reduced after the ASHA cadre was introduced. If there is a disease outbreak in the village ASHA helps in organising camps. They do not distinguish between service provider roles and facilitator roles and see them both as necessary.

In summary whereas the NGO which conducted the training was firmly having a framework of understanding that saw ASHA as only a health activist, most state officials and district medical officers were in a framework of understanding-1 and both were equally critical of the final shape of the ASHA, even becoming hostile to the programme, as the ASHA they saw did not match their expectation of her. In contrast ANMs and ASHAs shared a more pragmatic understanding in line with national guidelines-what we called the framework of understanding-2.

In West Bengal most stakeholder groups subscribe to the link worker role, do not deny her the service provider roles, but make no active effort to support her in that role.

West Bengal

While the state leadership would prefer to have her concentrate exclusively on MCH work, they are resigned to the fact that she would have to be "shared" with other health programs. As in Assam, ASHA appear to be spending significant amounts of time on attending review meetings, service delivery sessions, and maintaining records and registers. One district CMOH would like to see them involved in all public health programmes; the state leadership would like to see them focus on MCH services. Another CMOH believes that ASHAs are not as effective in generating awareness as they are in gathering information and passing this on to ANM. One GP is paying them incentives to assist the total sanitation program. She is however considered a mobiliser of the community to get them to access services. So clearly in West Bengal most stakeholder groups subscribe to the *link worker role*, do not deny her the service provider roles, but make no active effort to support her in that role, and while no one denies a social activist role, no respondent mentioned a specific social activist role.

In Bihar the senior leadership at the state level feel that both the link worker and activist dimensions are important. Mid level officials at the state level feel that the selection, training and support in the state for ASHA so far have not been conducive for the activist role. At the district level some stakeholders see the ASHA as a link worker who can help achieving their targets.

Bihar

The ASHA training book lists eight tasks which include role in BCC, linking with health services as well as formation of village health plans. The senior leadership at the state level feel that both the *link worker and activist dimensions* are important and ASHA is helping in achieving the targets of immunisation, JSY and family planning. They want her to become more active in other national disease control programmes too. The senior leadership at the state level see the ASHA as the link between people who need services and the people who can provide the services. Mid level officials at the state level feel that the selection, training and support in the state for ASHA so far have not been conducive for the activist role. At the district level some stakeholders see the ASHA as a link worker who can help achieving their targets of immunisation, institutional delivery, family planning and other disease control programmes. Some other stakeholders see them as providing services for MCH, information collection for department, sputum collection, helping in Leprosy programme and promoting family planning, immunisation and institutional delivery. The Civil surgeon of one district perceived that the role of ASHA should go beyond being a link worker alone, and should also include counselling families on how

to access health services, provide preliminary treatment for common ailments and referring the serious cases. Some District level stakeholders, seeing her responsiveness would have the ASHA replace the ANM. Block level views differ significantly from the views of state level informants. According to them ASHA should cover the entire health sector including nutrition, sanitation, agriculture or whatever the government gives her a cash incentive for. Their perception was that ASHA motivation levels were high. Most block level teams feel that the activist role is undesirable or unnecessary or infeasible. However a few block level officials felt that social recognition would automatically lead her into the role of mobilise or activist.

The role of the Sahiyya across a range of stakeholders was predominantly conceived of as a 'link worker'. Sahiyya was needed to create awareness about health services and increase service utilisation.

Jharkhand

The role of the Sahiyya across a range of stakeholders was predominantly conceived of as a '*link worker*'. So the Mission Director, State RCH Officer, State Programme Manager, Civil Surgeons, Medical Officers, Deputy Commissioner and NGO leaders, trainers and Sahiyyas all agreed that the Sahiyya was needed to create awareness about health services and increase service utilisation. Some respondents saw her role more broadly as linking communities to health services and the health system whereas others saw her very specifically as linking the community to ANMs.

Section 2: Comparative Case Studies of the ASHA Selection Process

Case Studies – Assam: Karimganj and Dibrugarh

State authorities perceive that they followed the national guidelines for ASHA selection. Selection in Assam varied in the two districts. In Dibrugarh, selection was through a specially constituted an all woman village committee comprising SHG members, PRI members, ANM, AWW and the school teacher. These village committees were to be first given orientation at district level. The committees held consultations and invited applications in their village and finalised the ASHA selection with larger community level consultation meeting. ANM of the area was also involved in the process of finalisation of name. This was reported to be as per the state guidelines. Later with VHSCs formed they play the key role in ASHA selection.

In Dibrugarh, selection was through a specially constituted an all woman village committee comprising SHG members, PRI members, ANM, AWW and the school teacher. The committees held consultations and invited applications in their village and finalised the ASHA selection with larger community level consultation meeting.

In Karimganj, no such process as described for Dibrugarh was followed. Block teams were given orientation for ASHA selection process. Later informal discussions were held by Panchayat representatives at village level. Level of community consultation was not very high as perceived by key stakeholders and candidates for ASHA were nominated by the PRI with or without community consultation and the ANM.

Dibrugarh is a relatively better performing and better developed district of Assam. The Phase-II study findings show that about 85% of ASHAs mention some community level consultation being part of selection process, but only 5% of ASHAs reported any formal village/VHSC meeting to have taken place for selection. The largest section, 53% of ASHAs has been selected by ANM/AWW/HW in consultation with Community and 27% said they have been

selected by Panchayat members in consultation with community. Only 2% said they have been selected by 'Sarpanch/Panchayat member acting alone and 17% said ANM had acted alone.

In Karimganj according to the field responses of the study, the type of selection that finally resulted was different from Dibrugarh as about 62% said they were selected in a meeting of the Panchayat, with explicit community consultation in 21% Only 5% said they have been selected by 'Sarpanch/Panchayat member acting alone'. 13% of ASHAs reported a village/VHSC meeting to have taken place for selection. Though a low figure, this is higher than in Dibrugarh. ANM involvement in the selection was low.

ANM responses confirm this pattern with selection in Dibrugarh being in 40% ANM led and another 30% where they recommended it to the PRI. In Karimganj it was more often Panchayat led, with some degree of consultation with community and with each other. One thirds of AWWs and PRIs respondents accept playing a role and in two thirds denied having played any role.

In terms of age, educational qualification, number of households and its dispersion and in economic status, the profile was broadly as for all states, with little difference across the two districts and with the ASHA slightly older than in other states. If we look at asset ownership, the ASHAs of Karimganj seemed on the average a bit poorer-but then it is a poorer district. ASHAs from disadvantaged SC/ST and BPL sections were selected in proportion to their presence in the population. However Karimganj has 58% minority population, but only 38% ASHAs come from minority sections. One significant difference is that where 79% of Dibrugarh used a cycle to reach all hamlets, in Karimganj only 2% did so. Is this due to variation in assets, or culture of cycle use, or did ASHAs in one districts get cycles and in another did not?

In terms of final performance, drop outs, there were no major difference between the districts and whether the selection was ANM led or PRI led. The spirit of community consultation was maintained and the relatively good performance of ASHAs as compared to other states shows that the differing selection processes made little difference.

Case Studies – Orissa: Nayagarh and Angul

State guidelines, were stated to be in conformity with the national guidelines. However Orissa followed a very different process of selection. The first step is the development of a list of candidates selected during a meeting of SHG members, facilitated by the AWW and supervised by the ANM. One of these candidates is then decided on by a consensus. If a consensus is not reached, the candidate is selected by drawing lots, by voting (each SHG member has one vote), or the Block Medical Officer (BMO) makes the final arbitration based on qualifications and an interview. The method of voting was devised after the system of drawing lots resulted in selection of candidates who had the least support. The names have to be submitted to the BMO. Respondents reported increasing political interference in the process, and it is becoming more common to have the BMO make the selection. In Orissa, where female literacy is low, the state has taken a decision to relax the education level in those areas and have achieved 100% coverage by ASHA.

In Orissa, where female literacy is low, the state has taken a decision to relax the education level in those areas and have achieved 100% coverage by ASHA.

According to the responses of ASHAs, only about 14% of ASHAs in Nayagarh and 24% in Angul report being selected 'in a village/VHSC meeting' as a part of selection process. Most ASHAs perceived their selection as having been made by 'ANM or AWW in consultation with Community' – 67% in Nayagarh and 53% in Angul with another substantial section saying that it was by the ANM/AWW acting on her own 31% in Nayagarh and 26% in Angul. Being selected by the Sarpanch/Panchayat members in consultation with community is reported by about 34% of ASHA in Nayagarh and 37% in Angul. Only 1% in Nayagarh and 5% in Angul reported selection by the 'Sarpanch/Panchayat member acting alone'. Most ANMs when asked, perceive that they made the selection of ASHA- over 85%. And when AWWs are asked, their response is almost identical. And the good news is that almost 70% of PRI members also perceive the same- though their formal space was much less. Whatever the formal process, it has worked in building a sense of ownership in the decision in all key stakeholders.

The outcome of the selection process has been an ASHA of a similar age and socio-economic profile with a much more flexible relaxation of educational norms where a suitable educated ASHA is not available. Only 49% of ASHAs being above 8th class pass in tribal underdeveloped Nayagarh as compared to 72% in Angul district. In terms of economic status also the difference between the districts is sharp, with 64% of ASHAs in Nayagarh in BPL category as only 39% in Angul.

Drops outs have been minimal and functionality and effectiveness of the ASHA in Orissa has been amongst the best in the states studied. We could conclude that on many counts the selection process is robust and worthy of replication. The PRI has been involved.

Case Studies – Kerala: Trivandrum and Wayand

The outcome of the selection process In Kerala is an older ASHA, largely secondary school passed. The selection has not been too equity sensitive in terms of caste.

The first thing that strikes the analyst is the remarkable similarity in ASHA profile between the much urbanised Trivandrum district and the 17% tribal Wayanad district. Part of this should be attributed to very clear guidelines issued and implementation fidelity. The state policy for selection of ASHAs, was to give the role of ASHA selection in each Panchayat ward to a Committee consisting of Panchayat President/Chairperson of Municipality or Corporation, Ward Member/Councillor, Medical Officer and Junior Public Health Nurse (JPHN). Role of overall supervision of process was given to the District Health and Family Welfare Society (DH and FWS), and The District Programme Manager was designated as the District Nodal Officer to facilitate the selection process and organise the Trainings. The ownership of these stakeholders elected Panchayats and the line department staff, was therefore strong. However, the involvement of community was lacking and the entire processes of selection lacked the essential component of social mobilisation, environment building and communication on the need and importance of ASHA as a social health leader. The Kerala leadership articulates a position that the formal elected Panchayat represents the community completely and any other form of direct or mediated involvement is not welcome.

A committee of ANM and MOIC played a major role in the selection as reported by 35% ASHAs. Other ASHAs perceive their selection, as done by the ANM (27%) or done by the Panchayat members (23%) in consultation with some

community members. Only 15% report being selected 'in a village/VHSC meeting' as a part of selection process in Trivandrum. On the positive side less than 4% allege that the Panchayat member made their own choice without consultation. Responses from ANMs and PRI members confirm their role in over 80% of selections whereas AWW responses show that in only about 20% were they involved.

The outcome of the selection process include is an older ASHA, largely secondary school passed. The selection has not been too equity sensitive in terms of caste. It has adequate representation of minorities, but in Trivandrum with 11% SC population, only 8% ASHAs are from this section and in Wayanad with 17% ST population only 12% of ASHAs are from ST communities. In terms of poverty, the selection has been remarkably sensitive – for how else do we explain a 67% of ASHAs from the BPL category and about the same number having a monthly income below Rs. 1000. Population densities are large, and as much as 77% of ASHAs interviewed reported working in villages which need more than one ASHA. 98% serve over 101 house holds and of this about 38% serve over 250 households.

Curiously 11% of ASHAs in Trivandrum district report having been a village dai as compared to only 2% in Wayanad, and 14% as AWW helper, as their past experience. 22% of ASHAs have also reported past experience under 'Health Worker for State Government Programmes' category. About 78% had previously been associated with MSS Kudumbashree.

The outcome of the selection was also satisfactory in terms of the ASHAs ability to develop the needed knowledge and carry out the functions expected of her and her strong sense of motivation.

Case Studies – Rajasthan: Banswara and Bundi

As stated earlier, existing 'Sahayoginis' working in the Anganwadi program of the ICDS were declared to be ASHA Sahayogini in Rajasthan. GP members selected the ASHA with endorsement from the ICDS, and ANMs and MOs had no role in the process. A recent government order has made the Medical Officer of PHC responsible for further selections, weeding out and payment. Areas in Western Rajasthan where female literacy is low have no ASHA Sahayoginis. Stakeholders in Rajasthan feel that this criterion ought to be relaxed, but as yet there is no move to do so. In Rajasthan in cases of educated ASHA there is increasing reliance by the ANM and AWW on them for reporting and record maintenance.

Existing 'Sahayoginis' working in the Anganwadi program of the ICDS were declared to be ASHA Sahayogini in Rajasthan. In both districts Panchayats seem to have played the major role with over 52% reporting that the Sarpanch made the selection with consultation of the community. But in both districts about 15% felt that it was a unilateral decision of the sarpanch.

In both districts Panchayats seem to have played the major role with over 52% reporting that the Sarpanch made the selection with consultation of the community. But in both districts about 15% felt that it was a unilateral decision of the sarpanch. Formal applications had been sought in about 21% in Banswara as against only 3% in Bundi. About 24% of ASHAs in Banswara and 16% in Bundi reported a village/VHSC meeting to have taken place for selection process. When ANMs were asked only about 20% to 30% they had played any role, and when AWWs were asked about 30% said they had played a role and when PRI members are asked, they too mostly deny having had a role.

Age, educational qualification and marital status were all as per guidelines with no relaxations. Income levels were similar to other states and representation for SC

and ST was appropriate. Curiously, a much larger percentage of ASHAs expect a government job or have financial reasons as compared to other states.

In terms of functionality, in terms of motivation, the levels in Rajasthan are modest, and this no doubt reflects the lack of a clear process for selection.

Case Studies – Andhra Pradesh: East Godavari and Khammam

In Andhra Pradesh, the government held state, district and block level meetings in early 2005 to create awareness among public about the WHV programme and its objectives. The ANM and the Sarpanch play a major role in the selection of ASHA. The ANM recommends a list of eligible women to the Panchayat committees and the Sarpanch selects the most qualified person. Subsequently, Gram Panchayat members and VHSC members are informed about the process.

In Andhra Pradesh, after selection, those who could not pass the test were either asked to leave, or in some cases the training institute conducted evening classes; with a daily honorarium of Rs. 50/- per day, as an incentive.

In East Godavari 65% of ASHA's stated that their selection was done by ANM with or without consultation with AWW and community. In about 22% cases the Panchayat members or sarpanch selected with consultation of community, and in 16% of cases the sarpanch acted alone to select the ASHA. 12% of ASHAs had gone through the formal process of filing an application. Only 10% of ASHAs described a visible process of community consultation in the form of a meeting.

In Khammam district, the role of the Panchayats has been significantly stronger where as the role of the ANM with 46% ASHAs who were selected by ANM/ AWW with or without community consultation and village mobilisation was even less significant at 4% as against 10% in EG. Almost 59% of ASHAS reported being selected by Panchayat members in consultation with community and nearly 29% of ASHAs reported that sarpanch or Panchayat member acting alone was responsible for their selection.

The selection outcomes in terms of age, marital status and number of children are very similar in both districts. In terms of educational levels the flexibility to lower the VIII class bar has been applied more often in Khammam as 36% of ASHA were below this bar of which 6% reported never having been to school. In East Godavari about 20% of ASHAs reported schooling upto primary school level. After the ASHA selection, the organisation in charge of training conducted a reading and writing test, and those who could not pass the test were either asked to leave, or in some cases the training institute conducted evening classes; with a daily honorarium of Rs. 50/- per day, as an incentive. One nodal officer in a district perceived that a higher educational criterion is necessary in order to enable the ASHA to understand drug dispensing.

As regards community selection care has been taken to see that the percentage of SCs/ST is much higher in ASHAs, than their representation in the population.

It is difficult to comment on the viability of the selection process. The training has been not focussed on outcomes, and there has been such weak support after the first training programme that it would be difficult to attribute the programme weakness to the selection process. On the other hand a much higher

level of mobilisational activity, a much larger representation of marginalised sections, a much better representation of SC/STs in the beneficiaries all point to a more activism oriented woman having been selected. But no firm conclusions are possible.

Case Studies – West Bengal: Malda and Birbhum

The ASHA program was rolled out in the state in phases, starting with the pilot phase in 22 blocks in 2006–07. Until now, total 341 blocks (115 tribal and 226 non-tribal) have been taken up in five phases. The selection was through advertisement through the Pradhan of the GP and selection was by written test and interviews with Panchayat members. No community involvement through the Gram Sabha was reported. NGOs in the district felt that the process could not be managed at the GP level, and in fact preferred the application route since it appeared to be less susceptible to nepotism and other negative influences. Selection is a typical government recruitment process, with advertisement of posts (informally, through posters, word of mouth and other publicity at the village level), initiated through Panchayat members. The Pradhan collects applications and forwards to the Block level Samiti, comprised of BMOH, BDO, Pradhan,). A small group of BPHN (nodal person for interviews) and ANM, conduct interviews and the list of selected candidates is sent to the Block Samiti, which finalises and forwards this to District, then state level. This can take many months (one example of 10 months was quoted), although this multi-layered system was created to ensure that successive lower levels deliver lists on time. Political interference was reported from all states, but appears limited in the districts visited. There is consensus across the states that involving PRI alone in the process was inimical to the selection. Where a broad based set of stakeholders was involved, the selection appears fair. In West Bengal, the process of application was appealing to the health system stakeholders since they felt that this eliminated external interference.

Final selection in West Bengal unlike in other states depends on a written test and interview, necessitating a high academic qualification. The high educational qualification and strict adherence to the age category, has meant that in the so called "backward blocks/tribal villages" the state has been unable to identify ASHA and therefore precisely those areas which need the presence of an ASHA are deprived.

On the ground the end process seems remarkably similar to everywhere else, fewer village meetings and mobilisation as compared to any other states, but with less reliance on an ANM based selection-in about 8% of ASHAs, with or without some consultation, in one thirds a Panchayat playing the prominent role and in above 9% Panchayat acting on its own. The only difference was that a formal process of ASHAs applying for the job was followed in about 50% of ASHAs in Birbhum and about 28% in Malda. In West Bengal, the state's decision to restrict selection to women who had a Class X pass qualification, has resulted in an age-educational qualification mismatch, since few women in the current age cohort of ages 35–40 would have attended school until Class X. Final selection in West Bengal unlike in other states depends on a written test and interview, necessitating a high academic qualification. The high educational qualification and strict adherence to the age category, has meant that in the so called "backward blocks/tribal villages" the state has been unable to identify ASHA and therefore precisely those areas which need the presence of an ASHA are deprived. The justification of the high educational levels is that the ASHA be able to maintain the "Cohort Register".

The ASHAs perception is also largely that the decision was made by the Panchayats. With so much effort to front the role of the Panchayats, it comes

as a surprise that when PRI members are interviewed as high as 80% of PRI members in Birbhum and 66% of members in Malda denied having any role over the selection and only about 20% said they had a role. 72% of AWWs also denied any role and again only a 20% said they played a role. About one thirds of ANMs said they had played a role.

Whereas in Malda the percentage of selected ASHAs who are SC or ST is about the same as their presence in the population, in Birbhum, it is about half. Neither district has a sizeable ST population. This could just be representative of our sample and would not be a final comment on the issue. Both districts have a large Muslim population, and in the selection of ASHAs this has been adequately reflected.

Desire for formal employment and financial reasons for joining are relatively high in West Bengal-as could be expected on an advertisement and interview based selection process, devoid of any element of mobilisation. Functionality and effectiveness is modest and it is difficult to state that the selection process and outcomes were adequate and difficult to attribute programme weakness to this alone, though it may have contributed to undermining the activist component.

Case Studies – Bihar: Khagaria and Purnia

The national criteria were maintained, but the majority view of officials at all levels was that ASHA should be educated and preferably 10th pass rather than 8th. Officials at all levels in Bihar, perceived that educational qualifications were the single most important criteria in ASHA selection. The State Project Manager perceived that ASHAs who did not meet the educational qualification (about 40%) should not be part of the programme, in contrast to the perceptions of block level officials in Bihar, where officials were in favour of enabling illiterate ASHAs to become literate. A senior state official in Bihar felt that academic merit should be the only selection criteria and the entry of lower castes as a result of community based selection has been damaging to the programme However, a relaxation in these criteria was observed in Khagaria with about 22% as primary school pass. Some officials felt that as in Jharkhand, a VHSC kind of community structure should be constituted and they should select the ASHA. Other officials feel that their department's officers should select and Panchayats should not have any role. At the block level too, the feeling is that Panchayat led selection process was problematic and ANMs or Rogi Kalyan Samitis should select ASHA with or without local community's participation.

The selection of 26% of ASHAs in both districts of Bihar was ANM led and 46% were by Panchayat. In both contexts, it was largely with the ANM or the sarpanch acting in consultation with the community.

The selection of 26% of ASHAs in both districts of Bihar was ANM led and 46% were by Panchayat. In both contexts, it was largely with the ANM or the sarpanch acting in consultation with the community. However in less than 3% was there an actual village level meeting. There was thus clearly no mobilisation at any level whatsoever. When we look at ANM and PRI member responses ANMs have played a lead role in half the ASHA selections and PRI in the other half with some cooperation between the two. AWW was little involved.

The selected ASHA has been as per guidelines and the pattern has been discussed earlier. In Khagaria, 22% are below the specified VIII class level and only one such instance in Purnia district. Past experience of social work of any

sort has been very limited. Only 4.5% have ever worked as a Dai while 72% did not have any previous work experience.

Performance has been weak but motivation remains strong and the former is probably related to the very weak training and support. Selection though sub-optimal had not been a critical limitation.

Case Studies – Jharkhand: Dhanbad and West Singhbhum

Guidelines regarding Sahiyya selection remained consistent through the different phases of Sahiyya implementation. The guidelines differed from the national guidelines and did so consciously for three reasons a). There were no elected Panchayats in Jharkhand, b). There was conscious decision based on what was understood from the evaluation of the Mitanin programme that a Village Health Committee based selection facilitated by NGOs would be most effective and c). Because there was already an NGO led programme in place, adopting this approach in Jharkhand at the time that ASHA programme was announced.

The guidelines differed from the national guidelines and did so consciously for three reasons a). There were no elected Panchayats in Jharkhand, b). There was a conscious decision that a village health committee based selection facilitated by NGOs would be most effective and c). Because there was already an NGO led programme in place.

Sahiyyas were to be selected by Village Health Committees (VHC), facilitated by NGOs. NGOs said that the first phase of VHC formation and Sahiyya selection was spread over 18 months, in contrast to only 3 months in the second phase, thus affecting the quality of the process. While specifying the selection criteria, the NGO workers made it clear that there would be no fixed honorarium. In the experience of the NGOs, mostly poor people from the village came forward to become VHC members since the rich could not identify a means of benefitting by participating in the process. In Dhanbad, a more intensive process was followed by the Zilla Saksharta Samiti. To facilitate VHC formation, a Block level Committee was set up which appointed facilitators. These facilitators created awareness about the concept of Village Health Committees at the community level and set up a date for a village meeting. During the village meeting the focus was on ensuring women's attendance.

The process for selection of ASHAs, who are called Sahiyya in the state, was strongly supported by NGO facilitation. The Sahiyya program in the state had started even before the launch of NRHM, and was conceived collaboratively by the state govt., and civil society, public health organisations. With the launch of NRHM this program which was run in a pilot mode till then, was expanded to the whole state. The state guidelines for Sahiyya selection remained consistent through the different phases of Sahiyya implementation. In Jharkhand, a senior official in one of the districts felt that: "Minimum selection criteria for the Sahiyya should be 8th pass and she should be of middle socio-economic status. If she is of low status, she would not inspire confidence and if she is of high status, she would have no interest. She should be selected by a committee of different departments and Sarpanches so that she can relate to all departments."

The first phase of VHC formation and Sahiyya selection began in 2005, and was carried out over a period of 18 months, and selections were done at the hamlet level. Whereas in the second phase which began in 2006–07 the time period allowed for Sahiyya selection was only 3 months, which is said to

have affected the quality of the process. Also in this phase the Sahiyya was selected at the 1000 population level.

This is reflected in the same survey where nearly 100% of ASHAs in Dhanbad district and 58% of ASHAs in West Singhbhum district reported of a village committee meeting for selection as ASHA. 15% in both districts report selection by ANM and another 12% in West Singhbhum by the NGO facilitator. Checking with ANMs we find about half the ANMs perceiving themselves as involved in the process in West Singhbhum and only about one fourths in Dhanbad. About 30% of Anganwadi workers felt they had been consulted.

The selection outcome was in both districts a younger ASHA – about half of the ASHAs are in the age group of 25–35 yrs, (57%) and about 29% being in the 18 to 24 age bracket. Only 13% are above 36 years of age. Only 64% have more than the desired 8th class pass qualification in Dhanbad, as compared to 80% in West Singhbhum. This could be due to lack of suitable middle school passed candidates in the largely tribal district of Dhanbad. In terms of economic status also the ASHAs of West Singhbhum are significantly less well off with 62% being BPL as compared to 49% from Dhanbad. Both selection processes have done well with respect to giving representation for tribals and SC, with West Singhbhum even showing preferential selection. In summary – both are large districts with a large urban complex in them-and having a very poor rural hinterland. West Singhbhum is more dispersed. The process of selection has been about the same-and has more closely followed the village meeting route than any other district and with the ANMs playing some role. There are no Panchayats in the picture.

The village committee based selection seems to have led to a selection where motivation and voluntarism is high. Performance over-all was weak, but this may be due to contextual factors like poverty and difficulty in access because of dispersion of hamlets and a poor quality of support.

Section 3: Comparative Tables of the Functionality – Effectiveness Link

The table below examines the list of tasks that ASHAs were queried on, the components of functionality that were examined based on both ASHA and service user testimonies and the effectiveness as assessed from service user responses. The data on functionality and effectiveness are summarised in the eight tables that follow. Web tables for findings of the evaluation are available on http://nhsrcindia.org/thematic_data.php?thematic_resources_id=1

Even the indicators in the table, above are a short list from an almost ten times higher data-base. In selecting these indicators, we have chosen those which are most representative of that area of functionality and effectiveness of the ASHA.

We now go back to comparative case studies approach to examine each district and state as a separate and distinct case study to see how these factors interact and influence what has been documented as the functionality of the ASHA.

Kerala

Task	Functionality indicators	Effectiveness indicators (and one of its determinant-skills)
Counselling women on all aspects of pregnancy	**85% of the pregnant women line listed** from the ASHAs coverage area were ever **visited (received any service) by the ASHA** during pregnancy or after child birth up to 6 months - **Service user A** (TVM - 81% & Wayanad - 89%) **86% of service user A** reported that they were visited **at least thrice** by ASHA during antenatal period. (TVM – 85.3% & Wayanad - 86.8%) Of all the service users A who received JSY payment **29%** of service user A reported that **ASHA helped them in claiming the JSY payment.** (TVM - 33% & Wayanad - 25%) **57%** of service user A said that they were **counselled on post partum care.** (TVM - 46% & Wayanad - 68%) **62%** of service user A reported being **counselled on contraception during ANC.** (TVM - 61% & Wayanad - 63%) **79%** of service users A who had **complications reported that they were referred by ASHA to seek care.** (TVM - 60% & Wayanad - 97%)	**97%** of service user A opted for **institutional delivery** (TVM - 98% & Wayanad - 96%) (DLHS-III TVM - 98.9% & Wayanad - 95.4%). Of these 50% cited ASHA as a motivator for the institutional delivery. **89%** of Service user A reported having **at least three ANCs. (DLHS III – TVM - 99.5% & Wayanad - 97.8%)** **60%** of Service user A said that they **received the entitlements under the JSY.** (TVM - 58% & Wayanad - 62%) **53%** of service user A had an **ANC card made.** TVM - 39% & Wayanad - 68%). This indicator reflects the quality of ANC, and is one which ASHAs are required to facilitate. **Knowledge** 95% of ASHAs knew of excessive bleeding and 25% knew of **foul smelling discharge as a danger sign** in post partum care. (TVM - 30% & Wayanad - 20%)
Accompanying women for delivery	**9.4%** of Service users A who had institutional delivery reported that they were **accompanied by ASHAs.** (TVM - 11% & Wayanad - 8%) **7.7% of pregnant women line listed** who were escorted for delivery services. (TVM - 8.8% & Wayanad - 6.7%) **14.3%** service user A who opted for institutional delivery and reported that ASHA **assisted in arranging transport.** (TVM - 12% & Wayanad - 17%)	Companion JSY study would be informative of effectiveness. but ASHAs further role at the institution is limited.
Attending Immunisation session – to promote ANC and immunisation attendance	88% of ASHAs self reported attending at least 3 sessions in last 3 months. (TVM - 92% & Wayanad - 84%) 91% of AWWs and 58% of the ANMs reported that ASHA is always present for the immunisation session. (TVM - 56% & Wayanad - 60%) Of all the service user B – children who received any vaccination 94% stated that immunisation was facilitated by ASHA (TVM - 93% & Wayanad - 94%)	**89%** of Service user A reported having **at least three ANCs. (DLHS III – TVM - 99.5% & Wayanad - 97.8%)** 98% of service user B – children received any immunisation. (TVM - 97% & Wayanad - 99%) Of all service user B who received any vaccination 83% were immunised for measles. (TVM - 90% & Wayanad - 76%) **Knowledge** 45% of ASHAs knew the correct vaccines to be given at 10 weeks. (TVM - 38% & Wayanad - 52%) 91% of ASHAs knew that measles vaccine is to be given at 9 months. (TVM - 90% & Wayanad - 92%)
Family planning	ASHAs functionality in promoting family planning services were assessed only in terms of number of cases that were successfully referred. Hence this is reported in the effectiveness column. Using the opportunity for FP promotion during ANC and PNC is assessed as a measure of functionality.	85% of ASHAs have "successfully" referred one or more cases of female sterilisation in last six months (TVM - 82% & Wayanad - 88%). Of these 74% have referred upto five cases in the same period (TVM - 69% & Wayanad - 78%) and 11% have referred between 6 to 10 cases.

	62% of service user A reported being **counselled on contraception during ANC.** (TVM - 61% & Wayanad - 63%) 52% of service user A reported receiving advice on contraception during PNC period. (TVM - 44% & Wayanad - 59%)	58% of ASHAs had referred one or more cases for IUD in the last six months. (TVM - 56% & Wayanad - 60%) About 13% of ASHAs have "successfully" referred one or more cases of male sterilisation in last six months. (TVM - 5% & Wayanad - 21%) **Knowledge** 98% of ASHAs knew correct choice of contraception for a newly wed couple. (TVM - 96% & Wayanad - 100%) 99% of ASHAs knew the correct choice of contraception for spacing in a woman who is breastfeeding – recently delivered. (TVM - 97% & Wayanad - 100%)
Visiting newborn for advice/care	11% of Service user A reported being visited by ASHA on day of birth. (TVM - 13% & Wayanad - 9%) and 66% reported two or more visits in the first month after delivery. (TVM - 75% & Wayanad - 57%) 21% of Service user A reported that ASHA was present during weighing of newborn. (TVM - 35% & Wayanad - 7%) 91% of Service user A reported that ASHA advised them on early breast-feeding. (TVM - 88% & Wayanad - 94%) 12% of Service user A said that ASHA was present and helped in early breastfeeding. (TVM - 14% & Wayanad - 11%). This is not a programme requirement, but captures the ASHAs initiative in assisting the mother and newborn. Of service user A who reported that the newborn was sick in first month 41% said that ASHA helped in identifying danger signs for the sick newborn. (TVM - 29% & Wayanad - 56%) in comparison to 7% reporting that AWW also provided such support. (TVM - 2% & Wayanad - 13%) 56% of Service user A who had a sick newborn reported seeking advice from the ASHA on appropriate care (TVM - 46% & Wayanad - 70%). In contrast to 8% seeking advice from AWW. (TVM - 4% & Wayanad - 14%)	99% of Service user A reported that their newborns were weighed on first day of birth. (TVM - 100% & Wayanad - 98%) 92% of Service user A reported that they had breastfed the newborn within four hours of birth. (0.4% of Service Users A reported breastfeeding the baby in the first hour after birth). 96% of Service user B reported exclusive breastfeeding on first three days. (TVM - 95% & Wayanad - 97%) **Knowledge** 99% of ASHA knew that it was key to initiate breast feeding within the first hour. (TVM - 98% & Wayanad - 99%) 94% of ASHA knew that the newborns should be exclusively breastfed from birth. (TVM - 88% & Wayanad - 99%)
General household visits & Nutrition counselling	97% of ASHAs reported making routine household visits. (TVM - 96% & Wayanad - 98%) 91% of Service user A reported that ASHA provided advice on early breast-feeding. (TVM - 88% & Wayanad - 94%) 89% of ASHAs said that they provided nutrition counselling (TVM - 82% & Wayanad - 95%) Also see above: Task 5.	72% of user B said that they started complementary feeding at 6 months 69% of user B who reported availing of AWC services regularly (TVM - 69% & Wayanad - 68%). Of these, 87% said that ASHA helped in availing AWC services (TVM - 90% & Wayanad - 85%) **Knowledge** 37% of ASHAs knew that fats and oils had to be added to the food for complementary feeding. (TVM - 48% & Wayanad - 26%) 83% of ASHAs knew that the baby should be exclusively breastfed for six months. (TVM - 85% & Wayanad - 80%)

Common childhood illness – early and appropriate response	Of those user B – children who had diarrhoea about 92% said that ASHA had been approached, and had given ORS or referred. (TVM - 93% & Wayanad - 91%) Of those Service Users B – children with signs of ARI, 93% reported that ASHA had been approached, gave "medicine" or referred. (TVM - 87% & Wayanad - 100%)	Of those user B children who had diarrhoea, ASHA gave ORS from her kit to 83% of such children. (TVM - 82% & Wayanad - 83%). (DLHS III – Children with diarrhoea in last two weeks who received ORS TVM - 72% & Wayanad - 50.3%) 97% of Service User B with ARI reported that they had sought treatment. (TVM - 93% & Wayanad - 100%) (DLHS III – TVM - 91.6% & Wayanad - 87.7%) **Knowledge** 79% of ASHA knew how to prepare ORS. (TVM - 73% & Wayanad - 85%) 42% of ASHAs said they would advice continue feeding in case of a diarrhoea case. (TVM - 47% & Wayanad - 37%). 44% also said that they would advise for giving extra fluids. (TVM - 55% & Wayanad - 32%) 32% of ASHA specified that they would look for chest wall in drawing as one of the danger signs to suspect for pneumonia. (TVM - 36% & Wayanad - 28%) **Supply** Of the ASHAs with a drug kit on the day of interview 14% had paracetamol (TVM - 20% & Wayanad - 8%), 8% had cotrimoxazole (TVM - 16% & Wayanad - 1%) and 22% had ORS in their drug kit. (TVM - 29% & Wayanad - 14%)
Malaria and TB related work	59% of ASHAs reported doing any malaria related work. (TVM - 62% & Wayanad - 55%) 72% of ASHAs reported doing any TB related work. (TVM - 64% & Wayanad - 80%) 48% of ASHAs were able to state that there were TB patients in their area. Of these 44% reported 1-3 TB case in their area. (TVM - 41% & Wayanad - 47%)	Of the 48% of ASHA reporting TB cases in their area, 77% of ASHA reported that they were providers of DOTS for TB. (TVM - 74% & Wayanad - 80%) **Supply** Of ASHA who had drug kit 7% of ASHAs had Chloroquine in their drug kit. (TVM - 13% & Wayanad - 1%) **Knowledge** 99% of ASHAs knew of sputum collection in chronic cough. (TVM - 100% & Wayanad - 98%) 87% of ASHAs knew what drug to be given in a suspected malaria case. (TVM - 86% & Wayanad - 87%) 72% of ASHAs knew that blood slides had to be made in case of symptoms with fever and chills. (TVM - 77% & Wayanad - 66%)
NCD related work	Applicable only for Kerala. 83% of ASHAs said they are active in mobilisation for NCD camps. (TVM - 78% & Wayanad - 88%) 87% of ASHAs reported providing supportive care for the chronically ill, bed-ridden patient. (TVM - 81% & Wayanad - 92%)	

Village meeting or any collective meeting for health promotion	97% of ASHAs reported functional VHSC in village-triangulated with PRI responses and AWW responses. Of those above, 94% reported that VHSC had held at least one meeting in last three months. (TVM - 92% & Wayanad - 96%) Of those who reported functional VHSC - 98% of ASHAs reported being a member or member secretary. (TVM - 97% & Wayanad - 100%)	99% of ASHAs with functional VHSCs reported getting support. (TVM - 98% & Wayanad - 100%) Out of those reporting a functional VHSC in the village, 96% of ANMs, PRIs & AWWs felt that VHSCs support ASHA. And about 57% of PRIs, 50% of ANMs and 38% of AWWs stated that the ASHAs participated in making village health plan. 83% of ASHAs with functional VHSC reported that VHSCs provide support in water and sanitation activities. (TVM - 72% & Wayanad - 93%)
Other mobilisation activity-related to securing entitlements	68% of ASHAs reported being active on water and sanitation facilities (TVM - 54% & Wayanad - 82%) 61% of ASHAs were also active on ensuring availability of services from ANM & AWW. (TVM - 49% & Wayanad - 73%) 28% said they mobilise people against domestic violence. (TVM - 26% & Wayanad - 30%) 88% of ASHAs who reported marginalisation. (TVM - 82% & Wayanad - 93%). For providing services to marginalised sections – 61% reported organising health camps (TVM - 47% & Wayanad - 74%); 68% reported frequent household visits (TVM - 62% & Wayanad - 74%) and 41% said they try to enrol these households to AWC/SHC. (TVM - 31% & Wayanad - 51%)	Of those who reported a functional VHSC 50% of PRI. ANMs and AWWs reported that ASHAs flag important issues of the village during the VHSC. All the ANMs and AWW said that ASHAs are able to provide services to the marginalised sections of the village while 86% of PRIs said the same. (TVM - 88% and Wayanad - 85%)

Orissa

Task	Functionality indicators	Effectiveness indicators (and one of its determinant-skills)
Counselling women on all aspects of pregnancy	**76% of the pregnant women line listed** from the ASHAs coverage area were ever visited **(received any service) by the ASHA** during pregnancy or after child birth up to 6 months – ***Service user A*** (Nayagarh - 67% & Angul - 85%) **73% of service user A** reported that they were visited **at least thrice** by ASHA during antenatal period (Nayagarh - 61% & Angul - 83%) Of all the service users A who received JSY payment **50%** of service user A reported that **ASHA helped them in claiming the JSY payment.** (Nayagarh - 55% & Angul - 45%) **62%** of service user A said that they were **counselled on post partum care** (Nayagarh - 68% & Angul - 56%) **58%** of service user A reported being **counselled on contraception during ANC.** (Nayagarh - 59% & Angul - 57%) **89%** of service users A who had **complications reported that they were referred by ASHA to seek care.** (Nayagarh - 86% & Angul - 91%)	**93%** of service user A opted for **institutional delivery** (Nayagarh - 92% & Angul - 94%) (DLHS III – Nayagarh - 44.1% & Angul - 40.7%). Of these 94% cited ASHA as a motivator for the institutional delivery. **70%** of Service user A reported having **at least three ANCs.** (Nayagarh - 66% & Angul - 74%) (DLHS III – Nayagarh - 55.6% & Angul - 60.4%) **88%** of Service user A said that they **received the entitlements under the JSY.** (Nayagarh - 89% & Angul - 87%) **52%** of service user A had an **ANC card made. (Nayagarh - 62% & Angul - 43%).** This indicator reflects the quality of ANC, and is one which **ASHAs are** required to facilitate. **Knowledge** 75% of ASHAs knew of excessive bleeding and 37% knew of fouls smelling discharge as **a danger sign** in post partum care (Nayagarh - 51% & Angul - 22%)
Accompanying women for delivery	**83%** of Service users A who had institutional delivery reported that they were accompanied **by ASHAs.** (Nayagarh - 84% & Angul - 83%) 58.7% **of pregnant women line listed** who were escorted for delivery services. (Nayagarh - 52% & Angul - 66%) **78%** service user A who opted for institutional delivery and reported that ASHA **assisted in arranging transport.** (Nayagarh - 65% & Angul - 90%)	Effectiveness of institutional delivery leading to improved management of complications, is being assessed in the companion JSY study (currently underway) would be informative of effectiveness.
Attending Immunisation session – to promote ANC and immunisation attendance	91% of ASHAs self reported attending at least 3 sessions in last 3 months. (Nayagarh - 94% & Angul - 87%) Triangulating the ASHA report, 98% of the ANMs and 96% of AWW reported that ASHA is always present for the immunisation session. Of all the service user B – children who received any vaccination, 78% stated that immunisation was facilitated by ASHA (Nayagarh - 86% & Angul - 72%)	70% of Service user A had **at least three ANCs.** (Nayagarh - 66% & Angul - 74%) (DLHS III – Nayagarh - 55.6% & Angul - 60.4%) 99.7% of service user B – children received any immunisation. (Nayagarh - 99.4% & Angul - 100%) Of all the children who received any vaccination 65% were immunised for measles. (Nayagarh – 58% & Angul - 70%). (DLHS III – Nayagarh - 68% & Angul - 89%) **Knowledge** 24% of ASHAs knew the correct vaccines to be given at 10 weeks. (Nayagarh - 42% & Angul - 5%) 82% of ASHAs knew that measles vaccine is to be given at 9 months. (Nayagarh - 72% & Angul - 92%)
Family planning	ASHAs functionality in promoting family planning services were assessed only in terms of number of cases that were successfully referred. Hence this is reported in the effectiveness column. Using	65% of ASHAs have "successfully" referred one or more cases for female sterilisation in last six months (Nayagarh - 46% & Angul - 83%). Of these 41% have referred upto five cases in the

	the opportunity for FP promotion during ANC and PNC is assessed as a measure of functionality 58% of service user A reported being counselled on contraception during ANC. 59% of service user A reported receiving advice on contraception during PNC period.	same period (Nayagarh - 31% & Angul - 50%) and 8% have referred at least eleven cases. 29% of ASHAs had referred one or more cases for IUD in the last six months. (Nayagarh - 35% & Angul - 22%) Only 2% of ASHAs have "successfully" referred one or more cases of male sterilisation in last six months. **Knowledge** 89% of ASHAs knew correct choice of contraception for a newly wed couple. 52% of ASHAs knew correct choice of contraception for spacing in a woman who is breastfeeding – recently delivered. (Nayagarh - 54% & Angul - 50%)
Visiting newborn for advice/care	60% of Service user A reported being visited by ASHA on day of birth. (Nayagarh - 49% & Angul - 71%) and 75% reported two or more visits in the first month after delivery (Nayagarh - 70% & Angul - 79%) 93% of Service user A reported that ASHA was present during weighing of newborn. 73% of Service user A reported that ASHA advised them on early breast-feeding. 64% of Service user A said that ASHA was present and helped in early breastfeeding. (Nayagarh - 72% & Angul - 56%). This is not a programme requirement, but captures the ASHAs initiative in assisting the mother and newborn. Of service user A who reported that the newborn was sick in first month, 43% said that ASHA helped in identifying danger signs for the sick newborn (Nayagarh - 49% & Angul - 36%) in comparison to 15% of service user A reporting AWW also provided such support. (Nayagarh - 20% & Angul - 8%) 59% of Service user A who had a sick newborn reported seeking advice from the ASHA on appropriate care (Nayagarh - 71% & Angul - 42%). In contrast to 14% seeking advice from AWW (Nayagarh - 18% & Angul - 7%)	72% of Service user A reported that their newborns were weighed on first day of birth. (Nayagarh - 78% & Angul - 67%) 91% of Service user A reported that they had breastfed the newborn within four hours of birth. (7% of Service Users A reported breastfeeding the baby in the first hour after birth). 81% of Service user B reported exclusive breastfeeding on first three days. (Nayagarh - 83% & Angul - 79%) **Knowledge** 95% of ASHA knew that it was key to initiate breastfeeding within the first hour 83% of ASHA knew that the newborns should be exclusively breastfed from birth. (Nayagarh - 85% & Angul - 81%)
General household visits & Nutrition counselling	88% of ASHAs reported making routine household visits (Nayagarh - 90% & Angul - 85%) 73% of Service user A reported that ASHA provided advice on early breast-feeding. 71% of ASHAs said that they provided nutrition counselling (Nayagarh - 79% & Angul - 62%) Also see above: Task 5	49% of user B said that they started complementary feeding at 6 months. (Nayagarh - 43% & Angul - 55%) 75% of user B who reported availing of AWC services regularly. (Nayagarh - 76% & Angul - 75%). Of these, 65% said that ASHA helped in availing AWC services. **Knowledge** 0.5% of ASHAs knew that fats and oils had to be added to the food for complementary feeding (Nayagarh - 1% & Angul - 0%) 72% of ASHAs knew that the baby should be exclusively breastfed for six months (Nayagarh - 69% & Angul - 75%)

Common childhood illness – early and appropriate response	Of those user B – children who had diarrhoea about 90% said that ASHA had been approached, and had given ORS or referred. (Nayagarh - 92% & Angul - 89%) Of those Service Users B – children with signs of ARI, 97% reported that ASHA had been approached, gave "medicine" or referred. (Nayagarh - 94% & Angul - 98%)	Of those user B children who had diarrhoea, ASHA gave ORS from her kit to 83% of such children. (Nayagarh - 85% & Angul - 82%) (DLHS III – Children with diarrhoea in last two weeks who received ORS – Nayagarh - 48% & Angul - 49.1%) 99% of Service User B with ARI reported that they had sought treatment. (Nayagarh - 100% & Angul - 98%) (DLHS III – Nayagarh - 57.1% & Angul - 48%) **Knowledge** 65% of ASHA knew how to prepare ORS (Nayagarh - 62% & Angul - 67%) 36% of ASHAs said they would advise continue feeding in case of a diarrhoea case. (Nayagarh - 33% & Angul - 39%). 53% also said that they would advise for giving extra fluids. (Nayagarh - 54% & Angul - 52%) 69% of ASHA specified that they would look for chest wall in drawing as one of the danger signs to suspect for pneumonia. (Nayagarh - 66% & Angul - 72%) **Supply** Of the ASHAs with a drug kit on the day of interview 18% had Paracetamol (Nayagarh - 25% & Angul - 13%), 21% had Cotrimoxazole (Nayagarh - 20% & Angul - 22%) and 20% had ORS in their drug kit (Nayagarh - 22% & Angul - 17%)
Malaria and TB related work	80% of ASHAs reported doing any malaria related work. (Nayagarh – 76% & Angul – 84%) 52% of ASHAs reported doing any TB related work. 62% of ASHAs were able to state that there were TB patients in their area (Nayagarh - 70% & Angul – 54%), and only 3% said they did not know. Of these, 53% reported 1-3 TB case in their area, (Nayagarh - 60% & Angul - 45%)	Of the 62% of ASHA reporting TB cases in their area, 95% of ASHA reported that they were providers of DOTS for TB **Supply** Of ASHA who had drug kit 21% of ASHAs had Chloroquine in their drug kit. (Nayagarh - 25% & Angul - 18%) **Knowledge** 91% of ASHAs knew of sputum collection in chronic cough. (Nayagarh - 92% & Angul - 90%) 23% of ASHAs knew what drug to be given in a suspected malaria case (Nayagarh - 32% & Angul - 13%) 91% of ASHAs knew that blood slides had to be made in case of symptoms with fever and chills. (Nayagarh - 96% & Angul - 85%)
Village meeting or any collective meeting for health promotion	83% of ASHAs (Nayagarh - 87% & Angul - 78%) reported functional VHSC in village-triangulated with PRI responses and AWW responses Of those above, 87% reported that VHSC had held at least one meeting in last three months (Nayagarh - 84% & Angul - 91%) Of the ASHAs who reported a functional VHSC, 91% of ASHAs reported being a member or member secretary.	95% of ASHAs with functional VHSCs reported getting support. (Nayagarh - 92% & Angul - 97%) Out of those reporting a functional VHSC in the village, 97% of ANMs & AWWs felt that VHSCs support ASHA while 93% of PRIs said the same. And about 45% of PRIs, ANMS and AWWS stated that the ASHAs participated in making village health plan.

		59% of ASHAs with functional VHSC reported that VHSCs provide support in water and sanitation activities (Nayagarh - 54% & Angul - 65%)
Other mobilisation activity-related to securing entitlements	47% of ASHAs reported being active on water and sanitation facilities (Nayagarh - 51% & Angul - 43%) 46% of ASHA were also active on ensuring availability of services from ANM & AWW (Nayagarh - 40% & Angul - 51%) 19% said they mobilise people against domestic violence. (Nayagarh - 15% & Angul - 23%) 97% of ASHAs reported marginalised households in their coverage area For providing services to marginalised sections 7% reported organising health camps (Nayagarh - 4% & Angul - 11%) and 9% reported frequent household visits (Nayagarh - 8% & Angul - 11%).	Of those who reported a functional VHSC 50% of PRI. ANMs and AWWs reported that ASHAs flag important issues of the village during the VHSC. All the ANMs said that ASHAs are able to provide services to the marginalised sections of the village while 93% PRI and AWW said the same.

West Bengal

Task	Functionality indicators	Effectiveness indicators (and one of its determinant-skills)
Counselling women on all aspects of pregnancy	**67% of the pregnant women line listed** from the ASHAs coverage area were ever **visited (received any service) by the ASHA** during pregnancy or after child birth up to 6 months – **Service user A** (Malda - 53% & Birbhum - 86%) **75% of service user A** reported that they were visited **at least thrice** by ASHA during antenatal period (Malda - 71% & Birbhum - 80%) Of all the service users A who received JSY payment 71% of service user A reported that **ASHA helped them in claiming the JSY payment.** (Malda - 53% & Birbhum - 82%) **55%** of service user A said that they were **counselled on post partum care** (Malda - 53% & Birbhum - 57%) **54%** of service user A reported being **counselled on contraception during ANC.** (Malda - 56% & Birbhum - 53%) **74%** of service users A who had **complications reported that they were referred by ASHA to seek care.** (Malda - 70% & Birbhum - 80%)	**65%** of service user A opted for **institutional delivery** (Malda - 58% & Birbhum - 73%) (DLHS III – Malda - 28.6% and Birbhum - 48.7%). Of these 61% cited ASHA as a motivator for the institutional delivery. (Malda - 52% & Birbhum - 70%) **49%** of Service user A reported having **at least three ANCs.** (Malda - 56% & Birbhum - 41%) (DLHS III - Malda - 59.6% & Birbhum - 58%) **45%** of Service user A said that they **received the entitlements under the JSY.** (Malda - 31% & Birbhum - 61%) **69%** of service user A had an **ANC card made.** (Malda - 61% & Birbhum - 78%). This indicator reflects the quality of ANC, and is one which ASHAs are required to facilitate. **Knowledge** **88% of ASHAs knew of excessive bleeding and 26%** knew of **foul smelling discharge as a danger sign** in post partum care. (Malda - 27% & Birbhum - 24%)
Accompanying women for delivery	5% of Service users A who had institutional delivery reported that they were accompanied **by ASHAs.** 2% **of pregnant women line listed** who were escorted for delivery services. (Malda - 1% & Birbhum - 3%) **11%** service user A who opted for institutional delivery and reported that ASHA **assisted in arranging transport.** (Malda - 14% & Birbhum - 8%)	Companion JSY study would be informative of effectiveness but ASHAs further role at the institution is limited.
Attending Immunisation session – to promote ANC and immunisation attendance	90% of ASHAs self reported that attending at least 3 sessions in last 3 months. (Malda - 81% & Birbhum - 99%) Triangulating the ASHA report, 98% of the ANMs and 89% of AWWs reported ASHAs being always present for the immunisation session. Of all the service user B – children who received any vaccination 90% stated that immunisation was facilitated by ASHA (Malda - 86% & Birbhum - 95%)	**49%** of Service user A reported having **at least three ANCs.** (Malda - 56% & Birbhum - 41%) (DLHS III – Malda - 59.6% & Birbhum - 58%) 99.7% of service user B – children received any immunisation. (Malda - 99.4% & Birbhum - 100%) Of all service user B who got any vaccination 67% were immunised for measles. (Malda - 74% & Birbhum - 60%) (DLHS III – Malda - 78.6% & Birbhum - 96.7%) **Knowledge** 71% of ASHAs knew the correct vaccines to be given at 10 weeks. (Malda - 65% & Birbhum - 78%) 93% of ASHAs knew the measles vaccine is to be given at 9 months. (Malda - 96% & Birbhum - 90%)
Family planning	ASHAs functionality in promoting family planning services were assessed only in terms of number of cases that were successfully referred. Hence this is reported in the effectiveness column. Using the opportunity for FP promotion during ANC and PNC is assessed as a measure of functionality	89% of ASHAs have "successfully" referred one or more cases for female sterilisation in last six months. Of these 45% referred more than 11 cases in last six months. (Malda - 40.2% & Birbhum - 50.5%)

	54% of service user A reported being counselled on contraception during ANC. (Malda - 56% & Birbhum - 53%) 51% of service user A reported receiving advice on contraception during PNC period. (Malda - 62% & Birbhum - 39%)	46% of ASHAs had referred one or more cases for IUD in the last six months. 30% have "successfully" referred one or more cases of male sterilisation in last six months. **Knowledge** 96% of ASHAs knew correct choice of contraception for a newly wed couple. 89% of ASHAs knew correct choice of contraception for spacing in a woman who is breastfeeding – recently delivered. (Malda - 90% & Birbhum - 87%)
Visiting newborn for advice/care	12% of Service user A were visited by ASHA on day of birth and 59% reported two or more visits in the first month after delivery 50% of Service user A where ASHA was present during weighing of newborn (Malda - 67% & Birbhum - 29%) 84% of Service user A reported that ASHA advised them on early breast - feeding. (Malda - 76% & Birbhum - 94%) 6% of Service user A said that ASHA was present and helped in early breastfeeding. (Malda - 7% & Birbhum - 4%) This is not a programme requirement, but captures the ASHAs initiative in assisting the mother and newborn. Of service user A who reported that the newborn was sick in first month 29% said that ASHA helped in identifying danger signs for the sick newborn (Malda - 25% & Birbhum - 38%) in comparison to 9% of service user A reporting AWW also provided such support. (Malda - 11% & Birbhum - 5%) 42% of Service users A who had a newborn sickness and sought advice from ASHA for seeking care (Malda - 40% & Birbhum - 45%). In contrast to 7% seeking advice from AWW (Malda - 11% & Birbhum - 0%)	63% of Service user A reported that their newborns were weighed on first day of birth (Malda - 59% & Birbhum - 67%) 88% of Service user A reported that they had breastfed the newborn within four hours of birth. (Malda - 84% & Birbhum - 94%) (1% of Service Users A reported breastfeeding the baby in the first hour after birth). 91% of Service user B reported exclusive breastfeeding on first three days **Knowledge** 94% of ASHA knew that it was key to initiate breastfeeding within the first hour 90% of ASHA knew that the newborns should be exclusively breastfed from birth. (Malda - 84% & Birbhum - 98%)
General household visits and nutrition counselling	92% of ASHAs reported making routine household visits. 84% of Service user A reported that ASHA provided advice on early breast-feeding (Malda - 75% & Birbhum - 94%) 73% of ASHAs said that they provide nutrition counselling (Malda - 70% & Birbhum - 76%)	38% of user B said that they started complementary feeding at 6 months. (Malda - 41% & Birbhum - 36%) 68% of user B who reported availing of AWC services regularly. (Malda - 48% & Birbhum - 89%). Of these, 88% said that ASHA helped in availing AWC services. (Malda - 76% & Birbhum - 94%) **Knowledge** 8% of ASHAs knew that fats and oils had to be added to the food for complementary feeding. (Malda - 9% & Birbhum - 6%) 90% of ASHAs knew that the baby should be exclusively breastfed for six months. (Malda - 97% & Birbhum - 83%)

Common childhood illness – early and appropriate response	Of those user B – children who had diarrhoea about 82% said that ASHA had been approached, and had given ORS or referred. (Malda - 68% & Birbhum - 96%) Of those Service Users B – children with signs of ARI, 75% reported that ASHA had been approached, gave "medicine" or referred (Malda - 61% & Birbhum - 80%)	Of those user B children who had diarrhoea, ASHA gave ORS from her kit to 52% of such children. (Malda - 39% & Birbhum - 64%) (DLHS III – Children with diarrhoea in last two weeks who received ORS Malda - 22.7% & Birbhum - 49.1%) 97% of Service User B with ARI reported that they had sought treatment. (Malda - 89% & Birbhum - 100%) (DLHS III – Malda - 73.7% & Birbhum - 67.5%) **Knowledge** 44% of ASHA knew how to prepare ORS (Malda - 42% & Birbhum - 46%) 24% of ASHAs said they would advice continue feeding in case of a diarrhoea case. (Malda - 17% & Birbhum - 32%). 30% also said that they would advise for giving extra fluids (Malda - 31% & Birbhum - 29%) 45% of ASHA specified that they would look for chest wall in drawing as one of the danger signs to suspect for pneumonia. (Malda - 33% & Birbhum - 59%) **Supply** Of the ASHAs with a drug kit on the day of interview 54% had Paracetamol (Malda - 26% & Birbhum - 89%), 53% had Cotrimoxazole (Malda - 40% & Birbhum - 70%) and 55% had ORS in their drug kit (Malda - 26% & Birbhum - 91%)
Malaria and TB related work	52% of ASHAs reported doing any malaria related work. (Malda - 55% & Birbhum - 48%) 47% of ASHAs reported doing any TB related work. (Malda - 55% & Birbhum - 38%) 55% of ASHAs were able to state that there were TB patients in their area (Malda - 61% & Birbhum - 49%), and only 4% said they did not know. Of these, 49% reported 1-3 TB case in their area (Malda - 53% & Birbhum - 45%)	Of the 55% of ASHA reporting TB cases in their area, 83% of ASHA reported that they were providers of DOTS for TB. (Malda - 76% & Birbhum - 93%) **Supply** Of ASHA who had drug kit 22% of ASHAs had Chloroquine in their drug kit. (Malda - 21% & Birbhum - 24%) **Knowledge** 94% of ASHAs knew of sputum collection in chronic cough. (Malda - 95% & Birbhum - 92%) 30% of ASHAs knew what drug to be given in suspected malaria (Malda - 33% & Birbhum - 28%) 78% of ASHAs knew that blood slides had to be made in case of symptoms with fever and chills. (Malda - 80% & Birbhum - 75%)
Village meeting or any collective meeting for health promotion	17% of ASHAs (Malda - 12% & Birbhum - 23%) reported functional VHSC in village-triangulated with PRI responses and AWW responses Of those above, 66% reported that VHSC had held at least one meeting in last three months. (Malda - 67% & Birbhum - 65%) Of the ASHAs who reported a functional VHSC, 47% of ASHAs reported being a member or member secretary (Malda - 33% & Birbhum - 55%)	66% of ASHAs with functional VHSCs reported getting support (Malda - 75% & Birbhum - 60%) Out of those reporting a functional VHSC in the village, 89% of PRIs and AWWs and 67% of ANMs (Malda - 75% & Birbhum - 57%) felt that VHSCs support ASHA. And about 61% of PRIs (Malda - 58% & Birbhum - 67%), 67% of AWWS while 27% of ANMs (Malda - 13% & Birbhum - 43%) stated that the ASHAs participated in making village health plan

		28% of ASHAs with functional VHSC reported that VHSCs provide support in water and sanitation activities (Malda - 50% & Birbhum - 15%)
Other mobilisation activity-related to securing entitlements	24% of ASHAs reported being active on water and sanitation facilities (Malda - 28% & Birbhum - 20%) 15% of ASHAs also were active on ensuring availability of services from ANM & AWW (Malda - 18% & Birbhum - 13%) 12% also said they mobilise people against domestic violence. (Malda - 20% & Birbhum - 3%) 72% of ASHAs reported marginalised households in their coverage area (Malda - 60% & Birbhum - 86%) For providing services to marginalised sections 5% reported organising health camps, 13% reported frequent household visits and 5% reported doing steps to enrol these families to AWC/SHC.	Of those who reported a functional VHSC 58% of AWWs (Malda - 71% & Birbhum - 44%), 39% of PRI (Malda - 42% & Birbhum - 33%) and 33% ANMs (Malda - 13% & Birbhum - 57%) reported that ASHAs flag important issues of the village during the VHSC meetings. All the ANMs and PRI said that ASHAs are able to provide services to the marginalised sections of the village while 86% of the AWW said the same. (Malda - 81% & Birbhum - 91%)

Assam

Task	Functionality indicators	Effectiveness indicators, (and one of its determinants, i.e. Skills)
Counselling women on all aspects of pregnancy	77% of the pregnant women line listed from the ASHAs coverage area were ever visited (received any service) by the ASHA during pregnancy or after child birth up to 6 months – (Service Users A) (Dibrugarh - 74% & Karimganj - 78%) 67% of Service User A were visited at least thrice by ASHA (Dibrugarh - 87% & Karimganj - 48%) Of all the Service Users A who received JSY payment, 73% reported that ASHA helped them in claiming the JSY payment. (Dibrugarh - 86% & Karimganj - 55%) 27% of Service Users A were counselled on post partum care (Dibrugarh - 43% and Karimganj - 11%) 36% of service user A were counselled on contraception during ANC. (Dibrugarh - 59% and Karimganj - 13%) 71% of Service Users A who had complications were referred by ASHA to seek care. (Dibrugarh - 72% and Karimganj - 70%)	72% of Service Users A) opted for institutional delivery (Dibrugarh - 85% and Karimganj - 59%) (DLHS III data Dibrugarh: 49.8%, Karimganj: 22.4%). Of these 91% cited ASHA as a motivator for the institutional delivery 54% of Service Users A reported receiving at least three ANCs. (Dibrugarh - 80% & Karimganj - 28%) (DLHS III – Dibrugarh - 57.1% & Karimganj - 44.9%) 61% of Service Users A said that they received the entitlements under the JSY. (Dibrugarh - 71% & Karimganj - 51%) 64% of Service Users A had an ANC card made. (Dibrugarh - 72% & Karimganj - 56%). This indicator reflects the quality of ANC, and is one which ASHAs are required to facilitate. **Knowledge** 18% of ASHAs knew of foul smelling discharge (Dibrugarh - 28% and Karimganj - 7%) and 80% knew of excessive bleeding as a danger sign in post partum care.
Accompanying women for delivery	73% of Service users A who had institutional delivery reported that they were accompanied **by ASHAs.** (Dibrugarh - 75% & Karimganj - 71%) 41% of **pregnant women line listed** who were escorted for delivery services. (Dibrugarh - 47% & Karimganj - 33%) 46% Service Users A who opted for institutional delivery reported that ASHA assisted in arranging transport. (Dibrugarh - 49% & Karimganj - 43%).	Effectiveness of institutional delivery leading to improved management of complications, is being assessed in the companion JSY study (currently underway) would be informative of effectiveness.
Attending Immunisation session – to promote ANC and immunisation attendance	92% of ASHAs reported attending at least three sessions in the last three months. (Dibrugarh - 88% & Karimganj - 96%) Triangulating the ASHA report, 96% of the ANMs and 92% of AWWs reported that ASHA was always present for the immunisation session, Of the children who received any vaccination, as a subset of Service Users B, 70% stated that immunisation was facilitated by ASHA (Dibrugarh - 42% & Karimganj - 96%)	54% of Service Users A reported at least three ANCs. (Dibrugarh - 80% & Karimganj - 28%) (DLHS III data for three ANC visits: Dibrugarh - 57.1%, Karimganj - 44.9%): 98% of Service Users B reported that their-children received any immunisation. (Dibrugarh - 100% & Karimganj - 97%) Of all children who received any vaccination, 63% were immunised for measles. (Dibrugarh - 71% & Karimganj - 55%) (DLHS III data for measles: Dibrugarh - 92.2%, Karimganj - 42.9%) **Knowledge** 55% of ASHAs knew the correct vaccines to be given at 10 weeks. (Dibrugarh - 41% & Karimganj - 68%) 94% of ASHAs knew the measles vaccine is to be given at nine months. (Dibrugarh - 93% & Karimganj - 94%)

Family planning	ASHAs functionality in promoting family planning services were assessed only in terms of number of cases that were successfully referred. Hence this is reported in the effectiveness column. Using the opportunity for FP promotion during ANC and PNC is assessed as a measure of functionality. 36% of Service User A reported being counselled on contraception during ANC. (Dibrugarh - 59% & Karimganj - 13%) 11% of Service Users A reported receiving advice on contraception during PNC period. (Dibrugarh - 11% and Karimganj - 12%)	60% of ASHAs have "successfully" referred one or more cases for female sterilisation in the last six months. Of this, 18% have referred over five cases in the same period, and within this about 5% have referred at least eleven cases. 25% of ASHAs had referred one or more cases for IUD in the last six months. (Dibrugarh - 88% & Karimganj - 63%). 11% of ASHAs have "successfully" referred one or more cases per month for male sterilisation in last six months. (Dibrugarh - 12% & Karimganj - 10%) **Knowledge** 91% of ASHAs knew the correct choice of contraception for a newly wed couple. (Dibrugarh - 95% & Karimganj - 86%) 67% of ASHAs knew the correct choice of contraception for spacing in a woman who is breastfeeding or recently delivered. (Dibrugarh - 66% & Karimganj - 68%)
Visiting newborn for advice/care	41% of Service Users A reported being visited by ASHA on the first day of birth (Dibrugarh - 27% & Karimganj - 55%), and 78% reported two or more visits, in the first month after delivery (Dibrugarh - 81% & Karimganj - 75%) 55% of Service Users A reported that the ASHA was present during weighing of newborn (Dibrugarh - 48% & Karimganj - 63%) 64% of Service Users A reported that ASHA advised them on early breast-feeding. (Dibrugarh - 71% and Karimganj - 58%) 18% of Service Users A said that the ASHA was present and helped in early breastfeeding. (Dibrugarh - 16% and Karimganj - 19%). This is not a programme requirement, but captures the ASHAs initiative in assisting the mother and newborn. Of the Service Users A who reported that the newborn was sick in the first month, 26% said that ASHA helped in identifying danger signs for the sick newborn (Dibrugarh - 35% & Karimganj - 14%) in comparison to 2% of Service User A reporting that the AWW also (Dibrugarh - 3% & Karimganj - 0%) provided such support 50% of Service Users A who had a sick newborn reported seeking advice from the ASHA on appropriate care, (Dibrugarh - 49% & Karimganj - 50%), in contrast to 7% seeking advice from the AWW. (Dibrugarh - 11% & Karimganj - 1%)	71% of Service Users A reported that their newborns were weighed on the first day of birth. (Dibrugarh - 82% & Karimganj - 60%) 92% of Service User A reported that they had breastfed the newborn within four hours of birth. (Dibrugarh - 95% and Karimganj - 88%). (1.4% of Service Users A reported breastfeeding the baby in the first hour after birth). 84% of Service Users A reported exclusive breastfeeding on the first three days. (Dibrugarh - 88% & Karimganj - 79%) **Knowledge** 99% of ASHA knew that it was key to initiate breastfeeding within the first hour. (Dibrugarh - 100% & Karimganj - 98%) 84% of ASHA knew that the newborns should be exclusively breastfed from birth. (Dibrugarh - 78% & Karimganj - 89%)

General household visits and Nutrition counselling	67% of ASHAs reported making routine household visits. (Dibrugarh - 68% & Karimganj - 65%) 64% of Service Users A reported that ASHA provided advice on early breast-feeding. (Dibrugarh - 71% & Karimganj - 58%) 26% of ASHAs said that they provided nutrition counselling (Dibrugarh - 39% & Karimganj - 12%) Also see above: Task 5	32% of Service Users B started complementary feeding at 6 months. (Dibrugarh - 29% & Karimganj - 34%) 23% of Service Users B availed of AWC services regularly. (Dibrugarh - 34% & Karimganj - 13%). Of these 38% said that ASHA helped in availing AWC services. **Knowledge** 18% of ASHAs knew that fats and oils had to be added to the food for complementary feeding. (Dibrugarh - 5% & Karimganj - 31%) 83% of ASHAs knew that the baby should be exclusively breastfed for six months. (Dibrugarh - 85% & Karimganj - 80%)
Common childhood illness – early and appropriate response	Of those Service Users B – children who had diarrhoea, about 71% said that the ASHA had been approached, and had given ORS or referred. (Dibrugarh - 65% & Karimganj - 76%) Of those Service Users B – children with signs of ARI, 64% reported that ASHA had been approached, gave "medicine" or referred. (Dibrugarh - 58% & Karimganj - 77%)	Of those Service Users B – children who had diarrhoea, ASHA gave ORS from her kit to 54% of such children. (Dibrugarh - 38% & Karimganj - 69%) (DLHS III Children with diarrhoea in last two weeks who received ORS: Dibrugarh - 32.6%, Karimganj - 19.5%) 93% of Service User B with ARI reported that they had sought treatment. (Dibrugarh - 92% & Karimganj - 96%) (DLHS III data: Dibrugarh - 57.1%, Karimganj - 57.8%) **Knowledge** 75% of ASHA knew how to prepare ORS. (Dibrugarh - 92% & Karimganj - 57%) 44% of ASHAs said they would advise continued feeding in case of diarrhoea. (Dibrugarh - 54% & Karimganj - 33%). Only 14% of ASHA reported that they would also advise giving extra fluids. (Dibrugarh - 21% & Karimganj - 7%) 30% of ASHA specified that they would look for chest wall in drawing as one of the danger signs for pneumonia. (Dibrugarh - 29% & Karimganj - 31%) **Supply** Of the ASHAs with a drug kit on the day of interview only 18% had Paracetamol, (Dibrugarh - 0% & Karimganj - 35%), 6% had Cotrimoxazole (Dibrugarh - 0% & Karimganj - 12%) and 23% had ORS (Dibrugarh - 1% & Karimganj - 44%)
Malaria and TB related work	21% of ASHAs reported doing any malaria related work. (Dibrugarh - 21% & Karimganj - 20%) 11% of ASHAs reported doing any TB related work. 49% of ASHAs were able to state that there were TB patients in their area, and only 3% said they did not know. Of this, 44% reported 1-3 TB cases in their area (Dibrugarh - 35% & Karimganj - 53%)	Of the 49% of ASHA reporting TB cases in their area, 87% of ASHA reported that they were providers of DOTS for TB (Dibrugarh - 95% & Karimganj - 82%) **Supply** Of the ASHA who had a drug kit, 23% of ASHAs had chloroquine (Dibrugarh - 2% & Karimganj - 44%) **Knowledge** 90% of ASHAs knew of sputum collection in chronic cough. (Dibrugarh - 85% and Karimganj - 95%)

		66% of ASHAs knew what drug to be given in suspected malaria (Dibrugarh - 88% & Karimganj - 44%) 96% of ASHAs knew that blood slides had to be made in case of presentation of symptoms such as fever and chills. (Dibrugarh - 99% & Karimganj - 93%)
Village meeting or any collective meeting for health promotion	94% of ASHAs (Dibrugarh - 94% & Karimganj - 93%) reported functional VHSC in their village in contrast to 81% of the PRI, ANM & AWW. (Dibrugarh - 75% & Karimganj - 87%) Of those above, 75% of ASHAs reported that the VHSC had held at least one meeting in last three months (Dibrugarh - 86% & Karimganj - 65%) Of the ASHAs who reported a functional VHSC 97% of ASHAs reported being a member or member secretary. (Dibrugarh - 98% & Karimganj - 96%)	83% of ASHAs with functional VHSCs reported getting support (Dibrugarh - 89% & Karimganj - 78%). Out of those reporting a functional VHSC in the village, 93% of PRIs and AWWs felt that VHSCs support ASHA (Dibrugarh 99% & Karimganj - 87%) as compared to 88% ANMs who said the same (Dibrugarh - 100% & Karimganj - 77%) Only 17% of ASHAs with functional VHSC reported that VHSCs provide support in water and sanitation activities (Dibrugarh - 32% & Karimganj - 1.1%) About 40% of PRIs and AWWs stated that the ASHAs participated in making village health plan (Dibrugarh - 47% & Karimganj - 36%) while only 24% ANMs said the same (Dibrugarh - 40% & Karimganj - 9%)
Other mobilisation activity-related to securing entitlement	56% of ASHAs reported being active on water and sanitation issues (Dibrugarh - 74% & Karimganj - 38%) 34% of ASHAs were active in ensuring availability of services from ANM and AWW (Dibrugarh - 57% & Karimganj - 10%) 15% of ASHA reported that they mobilise people against domestic violence. (Dibrugarh - 29% & Karimganj - 0%) 85% of ASHAs reported marginalised households in their coverage area (Dibrugarh - 97% & Karimganj - 73%) For providing services to marginalised sections 15% reported organising health camps (Dibrugarh - 27% and Karimganj - 2%) 26% reported frequent household visits (Dibrugarh - 50% and Karimganj - 1%) 16% reported taking active steps to enrol these families to AWC/Sub centre (Dibrugarh - 30% and Karimganj - 1%)	43% of ANMs reported that ASHAs flag important issues of the village during the VHSC. (Dibrugarh - 60% & Karimganj - 27%) as against 30% of AWWs and PRI (Dibrugarh - 37% & Karimganj - 21%) All the ANMs said that ASHAs were able to provide services to the marginalised sections of the village while 90% of the AWW & PRI said the same. (Dibrugarh - 91% & Karimganj - 90%)

Rajasthan

Task	Functionality indicators	Effectiveness indicators (and one of its determinant-skills)
Counselling women on all aspects of pregnancy	**76% of the pregnant women line listed** from the ASHAs coverage area were ever **visited (received any service) by the ASHA** during pregnancy or after child birth up to 6 months – **Service user A** (Banswara - 77% & Bundi - 76) **61% of service user A** reported that they were visited **at least thrice** by ASHA during antenatal period Of all the service users A who received JSY payment **24%** of service user A reported that **ASHA helped them in claiming the JSY payment.** (Banswara - 14% & Bundi - 32%) **9%** of service user A said that they were **counselled on post partum care** (Banswara - 7% & Bundi - 11%) **17%** of service user A reported being **counselled on contraception during ANC.** (Banswara - 14% & Bundi - 19%) **76%** of service users A who had **complications reported that they were referred by ASHA to seek care.** (Banswara - 80% & Bundi - 72%)	**94%** of service user A opted for **institutional delivery** (Banswara - 92% & Bundi - 95%) (DLHS III – Banswara - 46.7% & Bundi - 53.4%). Of these 56% cited ASHA as a motivator for the institutional delivery. **52%** of Service user A reported having **at least three ANCs.** (Banswara - 57% & Bundi - 48%) (DLHS III – Banswara - 19% & Bundi - 32.5%) **88%** of Service user A said that they **received the entitlements under the JSY.** (Banswara - 86% & Bundi - 90%) **43** of service user A had an ANC **card made.** (Banswara - 40% & Bundi - 45%). This indicator reflects the quality of ANC, and is one which ASHAs are required to facilitate. **Knowledge** **81%** of ASHAs knew of excessive bleeding and **26%** knew of **foul smelling discharge as a danger sign** in post partum care. (Banswara - 27% & Bundi - 24%)
Accompanying women for delivery	**61%** of Service users A who had institutional delivery reported that they were accompanied **by ASHAs.** (Banswara - 53% & Bundi - 68%) 44% of **pregnant women line listed** who were escorted for delivery services. (Banswara - 37% & Bundi - 49%) **32%** service user A who opted for institutional delivery and reported that ASHA **assisted in arranging transport.** (Banswara - 22% & Bundi - 40%)	Effectiveness of institutional delivery leading to improved management of complications, is being assessed in the companion JSY study (currently underway) would be informative of effectiveness.
Attending Immunisation session – to promote ANC and immunisation attendance	92% of ASHAs self reported that attending at least 3 sessions in last 3 months. (Banswara - 88% & Bundi - 95%) Triangulating the ASHA report 93% of the ANMs (Banswara - 88% & Bundi - 100%) and 90% of AWWs reported ASHAs being always present for the immunisation session (Banswara - 91% & Bundi - 89%) Of all the service user B – children who received any vaccination 94% stated that immunisation was facilitated by ASHA (Banswara - 93% & Bundi - 95%)	**52%** of Service user A reported having **at least three ANCs.** (Banswara - 57% & Bundi - 48%) (DLHS III – Banswara - 19% & Bundi - 32.5%) 98% of service user B – children received any immunisation. (Banswara - 97% & Bundi - 99.5%) Of all service user B who got any vaccination 50% were immunised for measles. (Banswara - 47% & Bundi - 52%) (DLHS III – Banswara - 91.2% & Bundi - 65%) **Knowledge** 49% of ASHAs knew the correct vaccines to be given at 10 weeks. (Banswara - 42% & Bundi - 56%) 84% of ASHAs knew the measles vaccine is to be given at 9 months. (Banswara - 75% & Bundi - 93%)
Family planning	ASHAs functionality in promoting family planning services were assessed only in terms of number of cases that were successfully referred. Hence this is reported in the effectiveness column.	78% of ASHAs have "successfully" referred one or more cases for female sterilisation in last six months (Banswara - 63% & Bundi - 92%). Of these 65% have referred upto five cases in the

	Using the opportunity for FP promotion during ANC and PNC is assessed as a measure of functionality **17%** of service user A reported being **counselled on contraception during ANC.** (Banswara - 14% & Bundi - 19%) 18% of service user A reported receiving advice on contraception during PNC period. (Banswara - 16% & Bundi - 20%)	same period (Banswara - 57% & Bundi - 73%) while 11% have referred between 6-10 cases (Banswara - 4% & Bundi - 17%) 24% of ASHAs had referred one or more cases for IUD in the last six months. (Banswara - 19% & Bundi - 29%) Only 8% of ASHAs have "successfully" referred one or more cases of male sterilisation in last six months. **Knowledge** 88% of ASHAs knew correct choice of contraception for a newly wed couple. (Banswara - 78% & Bundi - 97%) 83% of ASHAs knew correct choice of contraception for spacing in a woman who is breastfeeding - recently delivered. (Banswara - 84% & Bundi - 81%)
Visiting newborn for advice/care	17% of Service user A were visited by ASHA on day of birth (Banswara - 13% & Bundi - 20%) and 65% reported two or more visits in the first month after delivery (Banswara - 61% & Bundi - 68%) 72% of Service user A reported that ASHA was present during weighing of newborn (Banswara - 66% & Bundi - 77%) 46% of Service user A reported that ASHA advised them on early breast-feeding. (Banswara - 47% & Bundi - 46%) 26% of Service user A said that ASHA was present and helped in early breastfeeding. (Banswara - 14% & Bundi - 37%). This is not a programme requirement, but captures the ASHAs initiative in assisting the mother and newborn Of service user A who reported that the newborn was sick in first month 39% said that ASHA helped in identifying danger signs for the sick newborn (Banswara - 40% & Bundi - 38%) in comparison to 14% of service user A reporting AWW also provided such support. (Banswara - 20% & Bundi - 8%) 42% of Service user A who had a sick newborn reported seeking advice from the ASHA on appropriate care (Banswara - 40% & Bundi - 45%). In contrast to 9% seeking advice from AWW	70% of Service user A reported that their newborns were weighed on first day of birth (Banswara - 64% & Bundi - 74%) 83% of Service user A reported that they had breastfed the newborn within four hours of birth. (Banswara - 74% & Bundi - 91%) (1.8% of Service Users A reported breastfeeding the baby in the first hour after birth). 77% of Service user B reported exclusive breastfeeding on first three days. (Banswara - 71% & Bundi - 82%) **Knowledge** 90% of ASHA knew that it was key to initiate breastfeeding within the first hour. (Banswara - 85% & Bundi - 95%) 82% of ASHA knew that the newborns should be exclusively breastfed from birth. (Banswara - 84% & Bundi - 80%)
General household visits & Nutrition counselling	70% of ASHAs reported making routine household visits. (Banswara - 78% & Bundi - 61%) 46% of Service user A reported that ASHA provided advice on early breast-feeding 54% of ASHAs said that they provided nutrition counselling (Banswara - 56% & Bundi - 51%) Also see above: Task 5	38% of user B said that they started complementary feeding at 6 months. (Banswara - 36% & Bundi - 40%) 50% of user B who reported availing of AWC services regularly. (Banswara - 55% & Bundi - 47%). Of these, 98% said that ASHA helped in availing AWC services.

		Knowledge 44% of ASHAs knew that fats and oils had to be added to the food for complementary feeding. (Banswara - 30% & Bundi - 57%) 89% of ASHAs knew that the baby should be exclusively breastfed for six months. (Banswara - 90% & Bundi - 87%)
Common childhood illness – early and appropriate response	Of those user B – children who had diarrhoea about 67% said that ASHA had been approached, and had given ORS or referred. (Banswara - 66% & Bundi - 67%) Of those user B children with signs of ARI, 64% reported that ASHA had been approached, gave "medicine" or referred	Of those user B children who had diarrhoea, ASHA gave ORS from her kit to 56% of such children. (Banswara - 59% & Bundi - 54%). (DLHS III – Children with diarrhoea in last two weeks who received ORS Banswara - 18.5% & Bundi - 41.4%) 92% of Service User B with ARI reported that they had sought treatment. (Banswara - 91% & Bundi - 93%) (DLHS III – 78.3% & Bundi - 80.1%) **Knowledge** 70% of ASHA knew how to prepare ORS (Banswara - 69% & Bundi - 71%) 22% of ASHAs said they would advise continue feeding in case of a diarrhoea case (Banswada - 14% & Bundi - 29%). 26% also said that they would advise for giving extra fluids (Banswara - 24% & Bundi - 27%) 52% of ASHA specified that they would look for chest wall in drawing as one of the danger signs to suspect for pneumonia (Banswara - 50% & Bundi - 53%) **Supply** Of the ASHAs with a drug kit on the day of interview 3.3% had Paracetamol (Banswara - 2% & Bundi - 4.1%), 6% had Cotrimoxazole and 6% had ORS in their drug kit (Banswara - 4% & Bundi - 7%)
Malaria and TB related work	32% of ASHAs reported doing any malaria related work. (Banswara – 23% & Bundi - 40%) 18% of ASHAs reported doing any TB related work. (Banswara - 14% & Bundi - 22%) 52% of ASHAs were able to state that there were TB patients in their area (Banswada - 44% & Bundi – 59%), and only 3% said they did not know. Of these, 47% reported 1-3 TB cases in their area, (Banswara - 39% & Bundi - 55%)	Of the 52% of ASHA reporting TB cases in their area, 68% of ASHA reported that they were providers of DOTS for TB (Banswara - 64% & Bundi - 72%) **Supply** Of ASHA who had drug kit 7.3% of ASHAs had chloroquine in their drug kit. (Banswara - 10% & Bundi - 5.5%) **Knowledge** 72% of ASHAs knew of sputum collection in chronic cough. (Banswara - 73% & Bundi - 71%) 74% of ASHAs knew what drug to be given in suspected malaria (Banswara - 61% & Bundi - 87%) 76% of ASHAs knew that blood slides had to be made in case of symptoms with fever and chills. (Banswara - 68% & Bundi - 84%)

Village meeting or any collective meeting for health promotion	77% of ASHAs (Banswara - 70% & Bundi - 84%) reported functional VHSC in village while 87% of the ANM, 67% of the AWW and only 41% of the PRI said the same. Of those above, 96% reported that VHSC had held at least one meeting in last three months (Banswara - 93% & Bundi - 99%) Of the ASHAs who reported a functional VHSC, 86% of ASHAs reported being a member or member secretary.	83% of ASHAs with functional VHSCs reported getting support (Banswara - 90% & Bundi - 77%). Out of those reporting a functional VHSC in the village, 85% of PRIs, ANMs and AWWs felt that VHSCs support ASHA. And about 50% of ANMs and AWWs stated that ASHAs participates in making village health plan while 38% of the PRIs said the same (Banswara - 33% & Bundi - 42%) 45% of ASHAs with functional VHSC reported that VHSCs provide support in water and sanitation activities. (Banswara - 40% & Bundi - 49%)
Other mobilisation activity-related to securing entitlements	56% of ASHAs reported being active on water and sanitation facilities (Banswara - 63% & Bundi - 48%) 26% of ASHAs also were active on ensuring availability of services from ANM & AWW (Banswara - 37% & Bundi - 15%) 29% also said they mobilise people against domestic violence. (Banswara - 35% & Bundi - 23%) 53% of ASHAs reported marginalised households in their coverage area (Banswara - 38% & Bundi - 67%) For providing services to marginalised sections 5% reported organising health camps (Banswara - 1% & Bundi - 9%), 12% reported frequent household visits (Banswara - 8% & Bundi - 15%) and 7% reported doing steps to enrol these families to AWC/SHC. (Banswara - 4% & Bundi - 10%)	Of those who reported a functional VHSC 37% of ANMs & 34% of AWW (Banswara - 29% & Bundi - 40%) reported that ASHAs flag important issues of the village during the VHSC as against 16% of PRI (Banswara - 18% & Bundi - 13%) Nearly 80% of ANMs, AWW and PRI said that ASHAs are able to provide services to the marginalised sections of the village.

Andhra Pradesh

Task	Functionality indicators	Effectiveness indicators (and one of its determinant-skills)
Counselling women on all aspects of pregnancy	**50% of the pregnant women line listed** from the ASHAs coverage area were ever **visited (received any service) by the ASHA** during pregnancy or after child birth up to 6 months – ***Service user A*** (Khammam - 68% & EG - 42%) **79% of service user A** reported that they were visited **at least thrice** by ASHA during antenatal period. (Khammam - 84% & EG - 76%) Of all the service users A who received JSY payment **81%** of service user A reported that **ASHA helped them in claiming the JSY payment.** (Khammam - 55% & EG - 86%) **27%** of service user A said that they were **counselled on post partum care** (Khammam - 10% & EG - 39%) **68%** of service user A reported being **counselled on contraception during ANC.** (Khammam - 52% & EG - 81%) **73%** of service users A who had **complications reported that they were referred by ASHA to seek care.** (Khammam - 71% & EG - 74%)	**94%** of service user A opted for **institutional delivery** (Khammam - 91% & EG - 96%) (DLHS III – Khammam - 69.1% & EG - 86.6%). Of these 56% cited ASHA as a motivator for the institutional delivery. (Khammam - 38% & EG - 69%) **82%** of Service user A reported having **at least three ANCs.** (Khammam - 79% & EG - 85%) (DLHS III – Khammam - 88.1% & EG - 93%) **30%** of Service user A said that they **received the entitlements under the JSY.** (Khammam - 12% & EG - 43%) **46%** of service user A had an **ANC card made.** (Khammam - 39% & EG - 50%). This indicator reflects the quality of ANC, and is one which **ASHAs are** required to facilitate. **Knowledge** **62%** of ASHAs knew of excessive bleeding and 33% knew of **foul smelling discharge as a danger sign** in post partum care. (Khammam - 45% & EG - 20%)
Accompanying women for delivery	**53%** of Service users A who had institutional delivery reported that they were accompanied **by ASHAs.** (Khammam - 30% & EG - 70%) 25% **of pregnant women line listed** who were escorted for delivery services. (Khammam - 19% & EG - 28%) **56%** service user A who opted for institutional delivery and reported that ASHA **assisted in arranging transport.** (Khammam - 42% & EG - 65%)	Effectiveness of institutional delivery leading to improved management of complications, is being assessed in the companion JSY study (currently underway) would be informative of effectiveness.
Attending Immunisation session – to promote ANC and immunisation attendance	84% of ASHAs self reported attending at least 3 sessions in last 3 months. (Khammam - 93% & EG - 75%) Triangulating the ASHA report, 74% of the ANMs (Khammam - 78% & EG - 72%) and 89% of AWWs reported ASHAs being always present for the immunisation session (Khammam - 93% & EG - 86%) Of all the service user B – children who received any vaccination 78% stated that immunisation was facilitated by ASHA (Khammam - 81% & EG - 75%)	**82%** of Service user A reported having **at least three ANCs.** (Khammam - 79% & EG - 85%) (DLHS III – Khammam - 88.1% & EG - 93%) 98% of service user B – children received any immunisation. (Khammam - 99% & EG - 98%) Of all service user B who got any vaccination 33% were immunised for measles. (Khammam - 42% & EG - 24%) (DLHS III – Khammam - 97% & EG - 94.4%) **Knowledge** 30% of ASHAs knew the correct vaccines to be given at 10 weeks. (Khammam - 53% & EG - 7%) 81% of ASHAs knew that measles vaccine is to be given at 9 months. (Khammam - 95% & EG - 67%)
Family planning	ASHAs functionality in promoting family planning services were assessed only in terms of number of cases that were successfully referred. Hence this is reported in the effectiveness column. Using the opportunity for FP promotion during ANC and PNC is assessed as a measure of functionality	84% of ASHAs have "successfully" referred one or more cases for female sterilisation in last six months (Khammam - 86% & EG - 82%). Of these 59% have referred upto five cases in the same period and 18% have referred between 6-10 cases.

	68% of service user A reported being **counselled on contraception during ANC.** (Khammam - 52% & EG - 81%) 51% of service user A reported receiving advice on contraception during PNC period. (Khammam - 34% & EG - 64%)	9% of ASHAs had referred one or more cases for IUD in the last six months. (Khammam - 4% & EG - 14%) 14% of ASHAs have "successfully" referred one or more cases of male sterilisation in last six months. (Khammam - 2% & EG - 26%) **Knowledge** 92% of ASHAs knew correct choice of contraception for a newly wed couple. (Khammam - 89% & EG - 95%) 92% of ASHAs knew correct choice of contraception for spacing in a woman who is breastfeeding – recently delivered. (Khammam - 94% & EG - 89%)
Visiting newborn for advice/care	46% of Service user A reported being visited by ASHA on day of birth (Khammam - 32% & EG - 56%) and 75% of Service user A were visited more than twice in the first month after (Khammam - 68% & EG - 80%) 67% of Service user A reported that ASHA was present during weighing of newborn. (Khammam - 53% & EG - 77%) 79% of Service user A reported that ASHA advised them on early breast-feeding. (Khammam - 74% & EG - 83%) 39% of Service user A said that ASHA was present and helped in early breastfeeding. (Khammam - 37% & EG - 41%). This is not a programme requirement, but captures the ASHAs initiative in assisting the mother and newborn. Of service user A who reported that the newborn was sick in first month 56% said that ASHA helped in identifying danger signs for the sick newborn (Khammam - 46% & EG - 64%) in comparison to 28% of service user A reporting AWW also provided such support. (Khammam - 18% & EG - 36%) 79% of Service user A who had a sick newborn reported seeking advice from the ASHA on appropriate care (Khammam - 62% & EG - 92%). In contrast to 29% seeking advice from AWW (Khammam - 31% & EG - 28%)	94% of Service user A reported that their newborns were weighed on first day of birth. (Khammam - 93% & EG - 95%) 90% of Service user A reported that they had breastfed the newborn within four hours of birth. (Khammam - 80% & EG - 98%) (13.4% of Service Users A reported breastfeeding the baby in the first hour after birth). 84% of Service user B reported exclusive breastfeeding on first three days (Khammam - 95% & EG - 73%) **Knowledge** 97% of ASHA knew that it was key to initiate breastfeeding within the first hour. (Khammam - 95% & EG - 98%) 90% of ASHA knew that the newborns should be exclusively breastfed from birth. (Khammam - 94% & EG - 86%)
General household visits and Nutrition counselling	89% of ASHAs reported making routine household visits. (Khammam - 98% & EG - 80%) 79% of Service user A reported that ASHA provided advice on early breast-feeding. (Khammam - 74% & EG - 83%) 87% of ASHAs said that they provided nutrition counselling (Khammam - 89% & EG - 85%) Also see above: Task 5	71% of user B said that they started complementary feeding at 6 months (Khammam - 73% & EG - 70%) 84% of user B who reported availing of AWC services regularly. (Khammam - 81% & EG - 86%). Of these, 93% said that ASHA helped in availing AWC services. **Knowledge** 39% of ASHAs knew that fats and oils had to be added to the food for complementary feeding. (Khammam - 65% & EG - 13%) 85% of ASHAs knew that the baby should be exclusively breastfed for six months. (Khammam - 83% & EG - 86%)

Common childhood illness – early and appropriate response	Of those user B – children who had diarrhoea about 85% said that ASHA had been approached, and had given ORS or referred (Khammam - 87% & EG - 84%) Of those user Bs children with signs of ARI, 96% reported that ASHA had been approached, gave "medicine" or referred. (Khammam - 94% & EG - 100%)	Of those user B children who had diarrhoea, ASHA gave ORS from her kit to 72% of such children. (Khammam - 70% & EG - 73%) (DLHS III – Children with diarrhoea in last two weeks who received ORS Khammam - 25.4% & EG - 19.2%) 93% of Service User B with ARI reported that they had sought treatment. (Khammam - 88% & EG - 100%) (DLHS III – Khammam - 83.1% & EG - 73.4%) **Knowledge** 45% of ASHA knew how to prepare ORS. (Khammam - 50% & EG - 40%) 37% of ASHAs said they would advise continue feeding in case of a diarrhoea case (Khammam - 56% & EG - 17%). 44% also said that they would advise for giving extra fluids (Khammam - 58% & EG - 29%) 51% of ASHA specified that they would look for chest wall in drawing as one of the danger signs to suspect for pneumonia (Khammam - 62% & EG - 40%) Of the ASHAs with a drug kit on the day of interview 23% had Paracetamol (Khammam - 13% & EG - 34%), 17% had Cotrimoxazole (Khammam - 11% & EG - 24%) and 24% had ORS in their drug kit (Khammam - 16% & EG - 31%)
Malaria and TB related work	67% of ASHAs reported doing any malaria related work. (Khammam - 69% & EG - 64%) 59% of ASHAs reported doing any TB related work. (Khammam - 75% & EG - 42%) 71% of ASHAs were able to state that there were TB patients in their area (Khammam - 63% & EG - 79%), and only 5% said they did not know. Of these, 53% reported 1-3 TB cases in their area (Khammam - 45% & EG - 60%)	Of the 71% of ASHA reporting TB cases in their area, 90% of ASHA reported that they were providers of DOTS for TB. (Khammam - 98% & EG - 84%) **Supply** Of ASHA who had drug kit 22% of ASHAs had chloroquine in their drug kit. (Khammam - 23% & EG - 21%) **Knowledge** 89% of ASHAs knew of sputum collection in chronic cough. (Khammam - 91% & EG - 87%) 43% of ASHAs knew what drug to be given in suspected malaria (Khammam - 64% & EG - 22%) 97% of ASHAs knew that blood slides had to be made in case of symptoms with fever and chills. (Khammam - 100% & EG - 94%)
Village meeting or any collective meeting for health promotion	59% of ASHAs (Khammam - 31% & EG - 86%) with functional VHSC in village triangulated with PRI and AWW. Of those above, 92% reported that VHSC had held at least one meeting in last three months (Khammam - 81% & EG - 95%) Of the ASHAs who reported a functional VHSC, 72% of ASHAs reported being a member or member secretary. (Khammam - 64% & EG - 74%)	92.3% of ASHAs with functional VHSCs reported getting support (Khammam - 83% & EG - 95%). Out of those reporting a functional VHSC in the village, 87% of PRIs (Khammam - 70% & EG - 97%), 95% of ANMs and AWWs felt that VHSCs support ASHA. And about 70-75% of ANMs, PRI and AWWs stated that ASHAs participates in making village health plan.

		45% of ASHAs with functional VHSC reported that VHSCs provide support in water and sanitation activities (Khammam - 52% & EG - 43%)
Other mobilisation activity-related to securing entitlements	53% of ASHAs reported being active on water and sanitation facilities (Khammam - 65% & EG - 40%) 62% of ASHAs also were active on ensuring availability of services from ANM & AWW (Khammam - 75% & EG - 48%) 26% also said they mobilise people against domestic violence. (Khammam - 39% & EG - 8%) 88% of ASHAs reported marginalised households (Khammam - 89% & EG - 86%) For providing services to marginalised sections. 21% reported organising health camps (Khammam - 16% & EG - 26%), 43% reported frequent household visits (Khammam - 46% & EG - 40%) and 23% reported doing steps to enrol these families to AWC/SHC. (Khammam - 19% & EG - 26%)	Of those who reported a functional VHSC 58% of AWW (Khammam - 69% & EG - 53%) and 40% of ANMs (Khammam - 46% & EG - 33%) & PRI (Khammam - 33% & EG - 45%) reported that ASHAs flag important issues of the village during the VHSC Nearly 95% of ANMs, AWW and PRI said that ASHAs are able to provide services to the marginalised sections of the village.

Bihar

Task	Functionality indicators	Effectiveness indicators (and one of its determinant-skills)
Counselling women on all aspects of pregnancy	**73% of the pregnant women line listed** from the ASHAs coverage area were ever **visited (received any service) by the ASHA** during pregnancy or after child birth up to 6 months – **Service user A** (Khagaria - 71% & Purnia - 74%) **59% of service user A** reported that they were visited **at least thrice** by ASHA during antenatal period (Khagaria - 57% & Purnia - 61%) Of all the service users A who received JSY payment 42% of service user A reported that **ASHA helped them in claiming the JSY payment.** (Khagaria - 59% & Purnia - 27%) **13%** of service user A said that they were **counselled on post partum care** (Khagaria - 17% & Purnia - 10%) **21%** of service user A reported being **counselled on contraception during ANC.** (Khagaria - 21% & Purnia - 22%) **69%** of service users A who had **complications reported that they were referred by ASHA to seek care.** (Khagaria - 67% & Purnia - 74%)	**81%** of service user A opted for **institutional delivery** (Khagaria - 80% & Purnia - 82%) (DLHS III – Khagaria - 25.3% & Purnia - 21.6%. Of these 75% cited ASHA as the main motivator for the institutional delivery. (Khagaria - 80% & Purnia - 70%) **21%** of **Service user A** reported having **at least three ANCs.** (Khagaria - 17% & Purnia - 24%) (DLHS III – Khagaria - 26.4% & Purnia - 19.4%) **64%** of Service user A said that they **received the entitlements under the JSY.** (Khagaria - 61% & Purnia - 66%) **32%** of service user A had an **ANC card made.** (Khagaria - 40% & Purnia - 24%). This indicator reflects the quality of ANC, and is one which ASHAs are required to facilitate. **Knowledge** **76% of ASHAs knew of excessive bleeding and 26%** of knew of **foul smelling discharge as a danger sign** in post partum care. (Khagaria - 37% & Purnia - 15%)
Accompanying women for delivery	**91%** of Service users A who had institutional delivery reported that they were accompanied **by ASHAs.** (Khagaria - 86% & Purnia - 96%) **54% of pregnant women line listed** who were escorted for delivery services. (Khagaria - 49% & Purnia - 59%) **45%** service user A who opted for institutional delivery and reported that ASHA **assisted in arranging transport.** (Khagaria - 37% & Purnia - 53%)	Effectiveness of institutional delivery leading to improved management of complications, is being assessed in the companion JSY study (currently underway) would be informative of effectiveness.
Attending Immunisation session – to promote ANC and immunisation attendance	96% of ASHAs self reported that attending at least 3 sessions in last 3 months. (Khagaria - 97% & Purnia - 94%) 73% of the ANMs (Khagaria - 52% & Purnia - 93%) and 88% of AWWs reported ASHAs being always present for the immunisation session (Khagaria - 84% & Purnia - 93%) Of all the service user B – children who received any vaccination 90% stated that immunisation was facilitated by ASHA (Khagaria - 85% & Purnia - 94%)	**21%** of Service user A reported having **at least three ANCs.** (Khagaria - 17% & Purnia - 24%) (DLHS III – Khagaria - 26.4% & Purnia - 19.4%) 99.7% of service user B – children received any immunisation. (Khagaria - 100% & Purnia - 99.3%) Of all service user B who got any vaccination 54% were immunised for measles. (Khagaria - 51% & Purnia - 56%) (DLHS III – Khagaria - 54.8% & Purnia - 5%). **Knowledge** 35% of ASHAs knew the correct vaccines to be given at 10 weeks. (Khagaria - 18% & Purnia - 51%) 88% of ASHAs knew the measles vaccine is to be given at 9 months. (Khagaria - 84% & Purnia - 91%)
Family planning	ASHAs functionality in promoting family planning services were assessed only in terms of number of cases that were successfully referred. Hence this	74% of ASHAs have "successfully" referred one or more cases for female sterilisation in last six months (Khagaria - 78% & Purnia - 70%).

	is reported in the effectiveness column. Using the opportunity for FP promotion during ANC and PNC is assessed as a measure of functionality 21% of service user A reported being counselled on contraception during ANC. (Khagaria - 21% & Purnia - 22%) 15% of service user A reported receiving advice on contraception during PNC period. (Khagaria - 15% & Purnia - 15%)	Of these 39% (Khagaria - 25% & Purnia - 16%) have referred upto five cases in the same period and 21% have referred 6-10 cases. (Khagaria - 25% & Purnia - 16%) 15% of ASHAs had referred one or more cases for IUD in the last six months. (Khagaria - 3% & Purnia - 26%) Only 3% of ASHAs have "successfully" referred one or more cases of male sterilisation in last six months. (Khagaria - 4% & Purnia - 2%) **Knowledge** 90% of ASHAs knew correct choice of contraception for a newly wed couple. (Khagaria - 82% & Purnia - 97%) 80% of ASHAs knew correct choice of contraception for spacing in a woman who is breastfeeding – recently delivered. (Khagaria - 74% & Purnia - 86%)
Visiting newborn for advice/care	47% of Service user A reported being visited by ASHA on day of birth (Khagaria - 45% & Purnia - 49%) and 60% reported two or more visits in the first month after delivery (Khagaria - 58% & Purnia - 63%) 70% of Service user A reported that ASHA was present during weighing of newborn (Khagaria - 63% & Purnia - 78%) 70% of Service user A reported that ASHA advised them on early breast-feeding. (Khagaria - 64% & Purnia - 75%) 31% of Service user A said that ASHA was present and helped in early breastfeeding. (Khagaria - 35% & Purnia - 28%). This is not a programme requirement, but captures the ASHAs initiative in assisting the mother and newborn. Of service user A who reported that the newborn was sick in first month 37% said that ASHA helped in identifying danger signs for the sick newborn (Khagaria - 33% & Purnia - 47%) in comparison to 10% of service user A reporting AWW also provided such support (Khagaria - 10% & Purnia - 11%) 39% of Service user A who had a newborn sickness and sought advice from ASHA for seeking care (Khagaria - 39% & Purnia - 41%). In contrast to 11% seeking advice from AWW (Khagaria - 13% & Purnia - 8%)	72% of Service user A reported that their newborns were weighed on first day of birth (Khagaria - 68% & Purnia - 75%) 82% of Service user A reported that they had breastfed the newborn within four hours of birth. (Khagaria - 72% & Purnia - 92%). (6% of Service Users A reported breastfeeding the baby in the first hour after birth). 70% of Service user B reported exclusive breastfeeding on first three days. (Khagaria - 62% & Purnia - 79%) **Knowledge** 91% of ASHA knew that it was key to initiate breastfeeding within the first hour. (Khagaria - 88% & Purnia - 94%) 92% of ASHA knew that the newborns should be exclusively breastfed from birth. (Khagaria - 89% & Purnia - 95%)
General household visits and Nutrition counselling	67% of ASHAs reported making routine household visits. (Khagaria - 68% & Purnia - 66%) 70% of Service user A reported that ASHA provided advice on early breast-feeding. (Khagaria - 64% & Purnia - 75%) 39% of ASHAs said that they provide nutrition counselling (Khagaria - 49% & Purnia - 29%) Also see above: Task 5	41% of user B said that they started complementary feeding at 6 months. (Khagaria - 39% & Purnia - 43%) 41% of user B who reported availing of AWC services regularly. (Khagaria - 29% & Purnia - 53%). Of these, 95% said that ASHA helped in availing AWC services.

		Knowledge 24% of ASHAs knew that fats and oils had to be added to the food for complementary feeding. 84% of ASHAs knew that the baby should be exclusively breastfed for six months. (Khagaria - 81% & Purnia - 86%)
Common childhood illness – early and appropriate response	Of those user B – children who had diarrhoea about 71% said that ASHA had been approached, and had given ORS or referred (Khagaria - 63% & Purnia - 91%) Of those user Bs children with signs of ARI, 67% reported that ASHA had been approached, gave "medicine" or referred. (Khagaria - 62% & Purnia - 80)	Of those user B children who had diarrhoea, ASHA gave ORS from her kit to 27% of such children. (Khagaria - 26% & Purnia - 27%) (DLHS III – Children with diarrhoea in last two weeks who received ORS – Khagaria - 11.4% & Purnia - 7.6%) 95% of Service User B with ARI reported that they had sought treatment. (Khagaria - 96% & Purnia - 92%) (DLHS III – Khagaria - 84% & Purnia - 64%) **Knowledge** 44% of ASHA knew how to prepare ORS (Khagaria - 10% & Purnia - 78%) 1.5% of ASHAs said they would advise continue feeding in case of a diarrhoea case (Khagaria - 1% & Purnia - 2%). 2.5% also said that they would advise for giving extra fluids (Khagaria - 1% & Purnia - 4%) 45% of ASHA specified that they would look for chest wall in drawing as one of the danger signs to suspect for pneumonia. (Khagaria - 60% & Purnia - 29%)
Malaria and TB related work	17% of ASHAs reported doing any malaria related work. (Khagaria - 21% & Purnia - 13%) 42% of ASHAs reported doing any TB related work. (Khagaria - 32% & Purnia - 52%) 64% of ASHAs were able to state that there were TB patients in their area (Khagaria - 58% & Purnia - 69%), and only 3% said they did not know. Of these, 53% reported 1 - 3 TB cases in their area, (Khagaria - 47% & Purnia - 58%)	Of the 64% of ASHA reporting TB cases in their area, 79% of ASHA reported that they were providers of DOTS for TB (Khagaria - 71% & Purnia - 87%) **Knowledge** 81% of ASHAs knew of sputum collection in chronic cough. (Khagaria - 78% & Purnia - 84%) 0.5% of ASHAs knew what drug to be given in suspected malaria (Khagaria - 1% & Purnia - 0%) 72% of ASHAs knew that blood slides had to be made in case of symptoms with fever and chills. (Khagaria - 63% & Purnia - 81%)
Village meeting or any collective meeting for health promotion	6% of ASHAs (Khagaria - 2% & Purnia - 10%) reported functional VHSC in village-triangulated with PRI responses and AWW responses Of those above, 58% reported that VHSC had held at least one meeting in last three months (Khagaria - 50% & Purnia - 60%) Of the ASHAs who reported a functional VHSC, 42% of ASHAs reported being a member or member secretary. (Khagaria - 50% & Purnia - 40%)	58% of ASHAs with functional VHSCs reported getting support (Khagaria - 50% & Purnia - 60%) Out of those reporting a functional VHSC in the village, 63% of PRIs & AWWs felt that VHSCs support ASHA while 53% of ANMs said the same. And about 21% of PRI and AWWs and 13% ANMs stated that ASHAs participates in making village health plan. 17% of ASHAs with functional VHSC reported that VHSCs provide support in water and sanitation activities (Khagaria - 50% & Purnia - 10%)

Other mobilisation activity-related to securing entitlements	17% of ASHAs reported being active on water and sanitation facilities (Khagaria - 13% & Purnia - 21%) 20% of ASHAs also were active on ensuring availability of services from ANM & AWW (Khagaria - 13% & Purnia - 26%) 8% also said they mobilise people against domestic violence. (Khagaria - 1% & Purnia - 15%) 72% of ASHAs reported marginalised households (Khagaria - 78% & Purnia - 66%) For providing services to marginalised sections 3% reported organising health camps (Khagaria - 3% & Purnia - 2%), 16% reported frequent household visits (Khagaria - 22% & Purnia - 9%) and 19% reported doing steps to enrol these families to AWC/SHC. (Khagaria - 29% & Purnia - 9%)	Of those who reported a functional VHSC 36% of AWW (Khagaria - 100% & Purnia - 25%) and 20% of ANM (Khagaria - 0% & Purnia - 30%) and while none of the PRI reported that ASHAs flag important issues of the village during the VHSC. Nearly 89% of ANMs, AWW and PRI said that ASHAs are able to provide services to the marginalised sections of the village.

Jharkhand

Task	Functionality indicators	Effectiveness indicators (and one of its determinant-skills)
Counselling women on all aspects of pregnancy	**60% of the pregnant women line listed** from the ASHAs coverage area were ever visited **(received any service) by the ASHA** during pregnancy or after child birth up to 6 months – ***Service user A*** (West Singhbhum - 63% & Dhanbad - 55%) **60% of service user A** reported that they were visited **at least thrice** by ASHA during antenatal period (West Singhbhum - 50% & Dhanbad - 70%) Of all the service users A who received JSY payment **66%** of service user A reported that **ASHA helped them in claiming the JSY payment.** (West Singhbhum - 67% & Dhanbad - 63%) **32%** of service user A said that they were **counselled on post partum care** (West Singhbhum - 26% & Dhanbad - 40%) **45%** of service user A reported being **counselled on contraception during ANC.** (West Singhbhum - 49% & Dhanbad - 42%) **77%** of service users A who had **complications reported that they were referred by ASHA to seek care.** (West Singhbhum - 73% & Dhanbad - 82%)	**54%** of service user A opted for **institutional delivery** (West Singhbhum - 57% & Dhanbad - 52%) (DLHS III – West Singhbhum - 21.9% & Dhanbad - 35.4%). Of these 65% cited ASHA as a motivator for the institutional delivery (West Singhbhum - 76% & Dhanbad - 51%) **51%** of Service user A reported having **at least three ANCs.** (West Singhbhum - 44% & Dhanbad - 58%) (DLHS III – West Singhbhum - 40.4% & Dhanbad - 50%) **34%** of Service user A said that they **received the entitlements under the JSY.** (West Singhbhum - 47% & Dhanbad - 19%) **57%** of service user A had an **ANC card made.** (West Singhbhum - 64% & Dhanbad - 49%). This indicator reflects the quality of ANC, and is one which **ASHAs are required** to facilitate. **Knowledge** **79% of ASHAs knew of excessive bleeding and 27%** knew of **foul smelling discharge as a danger sign** in post partum care.
Accompanying women for delivery	**79%** of Service users A who had institutional delivery reported that they were accompanied **by ASHAs.** (West Singhbhum - 86% & Dhanbad - 70%) 26% **of pregnant women line listed** who were escorted for delivery services. (West Singhbhum - 31% & Dhanbad - 20%) **51%** service user A who went for institutional delivery and reported that ASHA **assisted in arranging transport.** (West Singhbhum - 62% & Dhanbad - 37%)	Effectiveness of institutional delivery leading to improved management of complications, is being assessed in the companion JSY study (currently underway) would be informative of effectiveness.
Attending Immunisation session – to promote ANC and immunisation attendance	87% of ASHAs self reported that attending at least 3 sessions in last 3 months. (West Singhbhum - 91% & Dhanbad - 83%) Triangulating the ASHA report, 84% of the (West Singhbhum - 81% & Dhanbad - 88%) and 86% of AWWs reported ASHAs being always present for the immunisation session Of all the service user B – children who received any vaccination 73% stated that immunisation was facilitated by ASHA (West Singhbhum - 57% & Dhanbad - 91%)	**51%** of Service user A reported having **at least three ANCs.** (West Singhbhum - 44% & Dhanbad - 58%) (DLHS III – West Singhbhum - 40.4% & Dhanbad - 50%) 94% of service user B - children received any immunisation. (West Singhbhum - 96% & Dhanbad - 92%) Of all service user B who got any v vaccination 64% were immunised for measles. (West Singhbhum - 70% & Dhanbad - 56%) (DLHS III – West Singhbhum - 78.5% & Dhanbad - 67.1%) **Knowledge** 27% of ASHAs knew the correct vaccines to be given at 10 weeks. (West Singhbhum - 13% & Dhanbad - 41%) 66% of ASHAs knew the measles vaccine is to be given at 9 months. (West Singhbhum - 51% & Dhanbad - 80%)

Family planning	ASHAs functionality in promoting family planning services were assessed only in terms of number of cases that were successfully referred. Hence this is reported in the effectiveness column. Using the opportunity for FP promotion during ANC and PNC is assessed as a measure of functionality **45%** of service user A reported being **counselled on contraception during ANC** (West Singhbhum - 49% & Dhanbad - 42%) 36% of service user A reported receiving advice on contraception during PNC period. (West Singhbhum - 32% & Dhanbad - 40%)	48% of ASHAs have "successfully" referred one or more cases for female sterilisation in last six months (West Singhbhum - 32% & Dhanbad - 63%). Of these 36% have referred upto five cases in the same period (West Singhbhum - 29% & Dhanbad - 42%) and 11% have referred 6–10 cases (West Singhbhum - 3% & Dhanbad - 18%) 27% of ASHAs had referred one or more cases for IUD in the last six months. (West Singhbhum - 18% & Dhanbad - 35%) 14% of ASHAs have "successfully" referred one or more cases of male sterilisation in last six months. (West Singhbhum - 22% & Dhanbad - 6%) **Knowledge** 82% of ASHAs knew correct choice of contraception for a newly wed couple. (West Singhbhum - 75% & Dhanbad - 89%) 67% of ASHAs knew correct choice of contraception for spacing in a woman who is breastfeeding - recently delivered. (West Singhbhum - 64% & Dhanbad - 69%)
Visiting newborn for advice/care	41% of Service user A reported being visited by ASHA on day of birth (West Singhbhum - 44% & Dhanbad - 38%) and 60% of Service user A were visited more than twice in the first month after (West Singhbhum - 57% & Dhanbad - 63%) 78% of Service user A reported that ASHA was present during weighing of newborn (West Singhbhum - 78% & Dhanbad - 79%) 83% of Service user A reported that ASHA advised them on early breast-feeding (West Singhbhum - 84% & Dhanbad - 81%) 31% of Service user A said that ASHA was present and helped in early breastfeeding. (West Singhbhum - 30% & Dhanbad - 32%). This is not a programme requirement, but captures the ASHAs initiative in assisting the mother and newborn Of service user A who reported that the newborn was sick in first month 48% said that ASHA helped in identifying danger signs for the sick newborn (West Singhbhum - 35% & Dhanbad - 74%) in comparison to 25% of service user A reporting AWW also provided such support. (West Singhbhum - 27% & Dhanbad - 21%) 56% of Service user A who had a sick newborn reported seeking advice from the ASHA on appropriate care (West Singhbhum - 47% & Dhanbad - 76%) In contrast to 14% seeking advice from AWW (West Singhbhum - 30% & Dhanbad - 15%)	49% of Service user A reported that their newborns were weighed on first day of birth (West Singhbhum - 47% & Dhanbad - 52%) 74% of Service user A reported that they had breastfed the newborn within four hours of birth. (West Singhbhum - 73% & Dhanbad - 76%). (4% of Service Users A reported breastfeeding the baby in the first hour after birth). 73% of Service user B reported exclusive breastfeeding on first three days (West Singhbhum - 81% & Dhanbad - 65%) **Knowledge** 93% of ASHA knew that it was key to initiate breastfeeding within the first hour. (West Singhbhum - 95% & Dhanbad - 92%) 84% of ASHA knew that the newborns should be exclusively breastfed from birth (West Singhbhum - 91% & Dhanbad - 78%)

General household visits and Nutrition counselling	57% of ASHAs reported making routine household visits. (West Singhbhum - 46% & Dhanbad - 67%) 83% of Service user A reported that ASHA provided advice on early breast-feeding (West Singhbhum - 84% & Dhanbad - 81%) 47% of ASHAs said that they provided nutrition counselling (West Singhbhum - 42% & Dhanbad - 51%) Also see above: Task 5	49% of user B said that they started complementary feeding at 6 months. (West Singhbhum - 50% & Dhanbad - 49%) 62% of user B who reported availing of AWC services regularly. (West Singhbhum - 70% & Dhanbad - 53%) Of these, 89% said that ASHA helped in availing AWC services. **Knowledge** 19% of ASHAs knew that fats and oils had to be added to the food for complementary feeding (West Singhbhum - 14% & Dhanbad - 23%) 92% of ASHAs knew that the baby should be exclusively breastfed for six months. (West Singhbhum - 91% & Dhanbad - 93%)
Common childhood illness – early and appropriate response	Of those user B – children who had diarrhoea about 73% said that ASHA had been approached, and had given ORS or referred (West Singhbhum - 69% & Dhanbad - 92%) Of those user Bs children with signs of ARI, 67% reported that ASHA had been approached, gave "medicine" or referred (West Singhbhum - 61% & Dhanbad - 74%)	Of those user B children who had diarrhoea, ASHA gave ORS from her kit to 37% of such children. (West Singhbhum - 43% & Dhanbad - 0%) (DLHS III – Children with diarrhoea in last two weeks who received ORS – West Singhbhum - 34.1% & Dhanbad - 9.2%) 88% of Service User B with ARI reported that they had sought treatment (West Singhbhum - 80% & Dhanbad - 98) (DLHS III – West Singhbhum - 25.7% & Dhanbad - 54.8%) **Knowledge** 39% of ASHA knew how to prepare ORS. (West Singhbhum - 27% & Dhanbad - 51%) 30% of ASHAs said they would advice continue feeding in case of a diarrhoea case (West Singhbhum - 31% & Dhanbad - 29%). 22% also said that they would advise for giving extra fluids (West Singhbhum - 24% & Dhanbad - 20%) 37% of ASHA specified that they would look for chest wall in drawing as one of the danger signs to suspect for pneumonia. (West Singhbhum - 8% & Dhanbad - 65%) Of the ASHAs with a drug kit on the day of interview 25% had Paracetamol (West Singhbhum - 8% & Dhanbad - 31%), 12% had cotrimoxazole (West Singhbhum - 4% & Dhanbad - 14%) and 32% had ORS in their drug kit (West Singhbhum - 13% & Dhanbad - 38%)
Malaria and TB related work	31% of ASHAs reported doing any malaria related work. (West Singhbhum - 39% & Dhanbad - 22%) 21% of ASHAs reported doing any TB related work. (West Singhbhum - 25% & Dhanbad - 17%) 45% of ASHAs were able to state that there were TB patients in their area (West Singhbhum - 51% and Dhanbad - 39%), and only 9% said they did not know. Of these, 39% reported 1–3 TB cases in their area, (West Singhbhum - 44% & Dhanbad - 33%)	Of the 45% of ASHA reporting TB cases in their area, 84% of ASHA reported that they were providers of DOTS for TB. (West Singhbhum - 80% and Dhanbad - 90%) **Supply** Of ASHA who had drug kit 33% of ASHAs had chloroquine in their drug kit. (West Singhbhum - 39% & Dhanbad - 13%)

		Knowledge 73% of ASHAs knew of sputum collection in chronic cough. (West Singhbhum - 66% & Dhanbad - 80%) 26% of ASHAs knew what drug to be given in suspected malaria (West Singhbhum - 47% & Dhanbad - 6%) 86% of ASHAs knew that blood slides had to be made in case of symptoms with fever and chills. (West Singhbhum - 84% & Dhanbad - 89%)
Village meeting or any collective meeting for health promotion	84% of ASHAs (West Singhbhum - 86% & Dhanbad - 83%) reported functional VHSC in village - triangulated with PRI responses and AWW responses Of those above, 56% reported that VHSC had held at least one meeting in last three months (West Singhbhum - 47% & Dhanbad - 65%) Of the ASHAs who reported a functional VHSC, 66% of ASHAs reported being a member or member secretary. (West Singhbhum - 56% & Dhanbad - 77%)	73.5% of ASHAs with functional VHSCs reported getting support (West Singhbhum - 64% & Dhanbad - 83%). Out of those reporting a functional VHSC in the village, 86% of PRIs (West Singhbhum - 81% & Dhanbad - 91%), 67% of AWWs (West Singhbhum - 56% & Dhanbad - 83%) and 74% said that VHSC provides support to ASHA. And about 68% of ANMs, 55% of PRI and 41% of AWWs stated that ASHAs participates in making village health plan 42% of ASHAs with functional VHSC reported that VHSCs provide support in water and sanitation activities (West Singhbhum - 43% & Dhanbad - 41%)
Other mobilisation activity-related to securing entitlements	62% of ASHAs reported being active on water and sanitation facilities (West Singhbhum - 54% & Dhanbad - 70%) 35% of ASHAs also were active on ensuring availability of services from ANM & AWW (West Singhbhum - 42% & Dhanbad - 28%) 16% also said they mobilise people against domestic violence. (West Singhbhum - 10% & Dhanbad - 22%) 61% of ASHAs reported marginalised households (West Singhbhum - 85% & Dhanbad - 38%) For providing services to marginalised sections 4% reported organising health camps (West Singhbhum - 7% & Dhanbad - 1%), 12% reported frequent household visits (West Singhbhum - 21% & Dhanbad - 3%) and 8% reported doing steps to enrol these families to AWC/SHC. (West Singhbhum - 14% & Dhanbad - 1%)	Of those who reported a functional VHSC 40% of ANMs, 31% of PRI and 13% of AWW reported that ASHA flags important issues of the village during the VHSC as against 100% of ANMs, 83% of PRI (West Singhbhum - 79% and Dhanbad - 92%) and 77% of AWW (West Singhbhum - 79% & Dhanbad - 67%) said that ASHAs are able to provide services to the marginalised sections of the village.

Annexure 1: List of Experts Involved in Phase I Evaluation

S. N.	State	Team members
1	**Assam**	Dr. Nupur Basu and Dr. Sulakshana Nandi
2	**Orissa**	Dr. Prasanta Tripathi and Dr. Mithun Som
3	**Rajasthan**	Dr. Nerges Mistry and Dr. Indu Capoor
4	**Bihar**	Mr. Sameer Garg and Mr. Haldar
5	**Jharkhand**	Dr. S. Ramanathan and Ms. Shilpa Deshpande
6	**Kerala**	Mr. V. R. Raman and Dr. Ganapathy
7	**West Bengal**	Dr. S. Sridhar, Dr. Vandana Prasad and Ms. Baishali Chatterjee
8	**Andhra Pradesh**	Dr. Dhruv Mankad, Dr. Samatha, and Dr. Suranjeen Prasad

Annexure 2: Phase II

S. N.	State	Districts	Agency
1	**Jharkhand**	Dhanbad West Singhbhum	PHRN PHRN
2	**Orissa**	Angul Nayagarh	PHRN PHRN
3	**Assam**	Dibrugarh Karimganj	NERRC NERRC
4	**Andhra Pradesh**	Khammam East Godavari	JVV (A.P.) JVV (A.P.)
5	**West Bengal**	Birbhum Malda	SMP SMP
6	**Kerala**	Wayanad Thiruvananthapuram	OASIS OASIS
7	**Rajasthan**	Banswara Bundi	NHSRC and CnFs NHSRC and CnFs
8	**Bihar**	Purnia Khagaria	PHRN PHRN

Annexure 3: Status of ASHA Selection (as on 31st March, 2011)

State Name	Proposed No. of ASHAs	No. of ASHA selected	% of ASHA selected
High Focus States			
Bihar	87,135	79,808	91.59%
Chhattisgarh	60,092	60,092	100%
Jharkhand	40,964	40,964	100%
Madhya Pradesh	52,117	50,113	96.1 5%
Orissa	41,102	40,942	99.61%
Rajasthan	54,915	47,209	85.97%
Uttar Pradesh	1,36,268	1,36,182	99.93%
Uttarakhand	11,086	11,086	100%
Total	**4,83,679**	**4,66,396**	**96.43%**
North Eastern States			
Assam	29,693	29,114	98.05%
Arunachal Pradesh	3,862	3,649	94.48%
Manipur	3,878	3,878	100%
Meghalaya	6,258	6,258	100%
Mizoram	987	987	100%
Nagaland	1,700	1,700	100%
Sikkim	666	666	100%
Tripura	7,367	7,367	100%
Total	**54,411**	**53,619**	**98.54%**
Non High Focus States			
Andhra Pradesh	70,700	70,700	100%
Delhi	5,400	3,622	67.66%
Gujarat	32,806	29,552	90.08%
Haryana	14,075	12,857	91.35%
Jammu & Kashmir	9,764	9,500	97.29%
Karnataka	39,195	33,105	84.46%
Kerala	32,854	31,868	97%
Maharashtra	59,383	59,151	99.60%
Punjab	17,360	16,597	95.60%
Tamil Nadu	6,850	2,650	38.68%
West Bengal	61,008	42,003	68.85%
Total	**3,49,395**	**3,11,605**	**89.53%**
Union Territories			
Andaman & Nicobar Island	407	407	100%
Dadra & Nagar Haveli	250	107	42.80%
Lakshadweep	85	83	97.64%
Chandigarh	423	423	100%
Total	**1,165**	**1,020**	**87.55%**
Grand total for All States and Union Territories			
	8,88,650	8,32,640	93.70%

Annexure 4: DLHS 3: 2007–08 (Percentages)

State	Districts	3 ANC check up visits	Institutional deliveries	Home deliveries by SBA	Children (12-23 months) who have received measles vaccine	Children with diarrhoea in the last two weeks who received ORS	Children with acute respiratory infection/ fever in the last two weeks who were given treatment
Andhra Pradesh	Khammam	88.1	69.1	4.8	97.0	25.4	83.1
	East Godavari	93.0	86.6	41.7	94.4	19.2	73.4
Assam	Dibrugarh	57.1	49.8	6.3	92.2	32.6	57.1
	Karimganj	44.9	22.4	6.5	42.9	19.5	57.8
Bihar	Purnia	19.4	21.6	2.9	5	7.6	64
	Khagaria	26.4	25.3	6.7	54.8	11.4	84
Jharkhand	Dhanbad	50.0	35.4	12.3	67.1	9.2	54.8
	West Singhbhum	40.4	21.9	10.9	78.5	34.1	25.7
Kerala	Trivandrum	99.5	98.9	0	97.3	72	91.6
	Wayanand	97.8	95.4	0	82.1	50.3	87.7
Orissa	Anugul	60.4	40.7	11.5	89.2	49.1	48
	Nayagarh	55.6	44.1	8.3	68.0	48	57.1
Rajasthan	Banswada	19.0	46.7	5.2	91.2	18.5	78.3
	Bundi	32.5	53.4	14.0	65.0	41.4	80.1
West Bengal	Birbhum	58	48.7	3.5	96.7	49.1	67.5
	Malda	59.6	28.6	2	78.6	22.7	73.7

"Coverage of primary healthcare systems — with the engagement of community health workers — needs to be comprehensive and universal and accompanied by sustained delivery of health services.

High level event on the Millennium Development Goals, United Nations Headquarters, 25 September 2008, Committing to action: achieving the Millennium Development Goals, Background note by the Secretary General."

"Given present pressures on health systems and their proven inability to respond adequately, the existing evidence overwhelmingly suggests that particularly in poor countries, CHW programmes are not a cheap or easy, but remain a good investment, since the alternative in reality is no care at all for the poor living in geographically peripheral areas. While there is a lot to learn, there is a lot we do know about making programmes work better: appropriate selection, continuing education, involvement and reorientation of health service staff and curricula, improvement supervision and support are non-negotiable requirements. These need political leadership and substantial and consistent provision of resources.

Community health workers: What do we know about them? Uta Lehmann and David Sanders, School of Public Health, University of the Western Cape."

National Health Systems Resource Centre
Technical Support Institution with National Rural Health Mission
Ministry of Health and Family Welfare
Government of India, New Delhi

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